NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, MARCH 4, 2021
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Lisa Bartlett, Alternate

REVISED AGENDA

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

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

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

The Board Meeting Agenda and supporting materials are available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima website at www.caloptima.org.

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

1) **Listen to the live audio at +1 (562) 247-8422 Access Code: 636-244-055 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/61644532643560976 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. Member Representative on Board of Directors
   b. Medi-Cal Rx Transition Delay
   c. California Advancing and Innovating Medi-Cal (CalAIM)
   d. Hospital Quality Assurance Fee Payments
   e. Virtual Engagement with Elected Officials
   f. Joint Advisory Committee Meeting

2. COVID-19 Update

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

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the February 4, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the November 19, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of the December 10, 2020 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the Minutes of the October 27, 2020 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

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

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

6. Consider Authorizing Modifications to CalOptima's Operations Policies and Procedures

7. Consider Authorizing Modifications to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks

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

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

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

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

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

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

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

15. Consider Approval of Modifications to Quality Improvement Policies

16. Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccine Incentive Program

17. Consider Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic

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

19. Consider Authorizing Amendments to CalOptima's Coordination and Provision of Public Health Care Services and Coordination and Provision of Behavioral Healthcare Services Agreements with the Orange County Health Care Agency

20. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2021-22

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

REPORTS

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

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

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses

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

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

27. Consider Authorizing a Contract with eVisit Services Vendor

~~S-1. Consider authorizing the preparation and release, subject to the Legal Ad Hoc's ("Ad Hoc") review of Requests for Information ("RFI") for an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers~~ ***Deleted per Ad Hoc Committee on 3/2/2021***

ADVISORY COMMITTEE UPDATES

28. Provider Advisory Committee Update

29. Member Advisory Committee Update

BOARD MEMBER COMMENTS

CLOSED SESSION

CS-1 Pursuant to Government Code Section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843
Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight FrankNegotiating Parties: Young S. Kim and Soon Y. Kim
Under Negotiation: Price and Terms of Payment

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on March 4, 2021 at 2:00 PM PDT at: https://attendee.gotowebinar.com/register/61644532643560976
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 (562) 247-8422

   Access Code: 636-244-055

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	February 24, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — March 4, 2021, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Welcomes Member Representative to the Board of Directors
Nancy Shivers, MSN, RN, CCM, was appointed by the Board of Supervisors to fill the open CalOptima Board seat for a member or family member of a member. Ms. Shivers' son, daughter and grandchildren are members of CalOptima. Ms. Shivers has been a nurse for more than 24 years and is familiar with health plan operations through her work as a case manager at Optum. She will attend her first meeting on March 4.

Medi-Cal Rx Transition Delayed While State Considers Magellan Conflict of Interest
On February 17, the Department of Health Care Services (DHCS) delayed again the April 1 go-live of Medi-Cal Rx, based on the need to review new conflict avoidance protocols submitted by Magellan Health. In January, Centene Corp. announced plans to acquire Magellan. Centene subsidiaries Health Net and California Health and Wellness operate managed care plans and pharmacies that participate in Medi-Cal. The state said the Centene transaction was unexpected and requires additional time to ensure that there will be acceptable firewalls between the entities to protect Medi-Cal members' pharmacy data and other proprietary information. No revised date for the Medi-Cal Rx launch was offered, but the state said it would provide an update in May. CalOptima will keep the Board and community informed about the twice-delayed transition.

COVID-19 Vaccination Efforts Take Priority as Pandemic Passes One-Year Milestone
February 26, 2021, marks one year since the original declaration of the COVID-19 public health emergency in Orange County. While maintaining strong access to testing and treatment for members, CalOptima is now working to support the vaccination phase that will move our community toward the end of the pandemic. Below are summaries of selected efforts on vaccination and other issues.

- *Permanent Telehealth Changes:* On February 2, DHCS released broad-based telehealth policy changes that would remain permanent following the end of the COVID-19 public health emergency. DHCS is seeking to modify or expand the use of synchronous telehealth, asynchronous telehealth, telephonic/audio-only and other virtual communication, and to add remote patient monitoring as a benefit. The changes would be effective July 1, 2021, after necessary federal approvals.
- *Member Mailing:* In late February, CalOptima members in Medi-Cal, OneCare Connect and OneCare will receive a mailing that includes a letter explaining the Board-approved $25 incentive for each vaccine received and a question-and-answer document that highlights

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vaccine safety and effectiveness. More than 552,000 mailings in seven languages were sent to members across the three programs.

- *Vaccine Equity Pilot Program (VEPP):* As of February 22, during the first three weeks of the VEPP, CalOptima has collaborated with the Orange County Health Care Agency (HCA) to directly allocate nearly 21,000 doses of COVID-19 vaccine to community health centers and health network providers. To be approved for a vaccine allocation, health networks had to identify CalVax-approved providers and commit to conducting personalized outreach to members to schedule appointments. CalOptima has asked health networks to report vaccine administration within 24 hours to the California Immunization Registry and aim for 100% vaccine utilization within each week. Recently, delivery of some doses was delayed because of inclement weather across the country, but resolution of that issue is expected soon.
- *Blue Shield:* According to a state contract released February 15, Blue Shield is now the third-party administrator of California's vaccine distribution effort. Subsequently, CalOptima learned that Orange County is in the second wave of counties where Blue Shield will lead the vaccine rollout, starting March 7. CalOptima will work with HCA to determine how this may impact future CalOptima-directed allocations under the VEPP.
- *Othena:* CalOptima and HCA facilitated a demonstration on February 11 of both the provider and member components of the Othena app. A total of 65 health network staff and CalVax providers attended the virtual demonstration. CalOptima recorded the event and has made it available for health networks to share with others who could not attend. Attendees provided positive feedback about their improved understanding of the provider registration process.
- *Program of All-Inclusive Care for the Elderly (PACE) Vaccination Events:* PACE is preparing to administer second doses to more than 270 participants and 50 staff on Saturday, February 27. A limited number of first doses will also be administered. When this effort is complete, approximately 77% of all PACE participants will be vaccinated.
- *Vaccination Awareness Campaign:* CalOptima's vaccination awareness ad campaign launched on February 11, with placement in local English, Spanish and Vietnamese language newspapers. Starting in March, ads for billboards, transit shelters, Spanish radio and social media will be added. The campaign will run through the end of June.
- *Media Coverage:* CalOptima received significant positive media coverage about our vaccine efforts in February. The Orange County Business Journal wrote about our member incentive program and PACE vaccination events, and the Orange County Register, Orange County Breeze and Patch ran articles about or made mention of the VEPP. On February 20, a commentary article with a shared byline from Interim Chief Medical Officer Emily Fonda, M.D., and Clayton Chau, M.D., Ph.D., Orange County Health Officer, HCA Director and CalOptima Board Member, ran in the Daily Pilot print edition and online here. The piece featured joint CalOptima-HCA efforts to support vaccination of vulnerable populations.

California Advancing and Innovating Medi-Cal (CalAIM) Documents Open for Comment
CalAIM is a multiyear initiative to improve Medi-Cal beneficiaries' quality of life and health outcomes by implementing delivery system, program and payment reforms. On February 16, DHCS released four draft documents about Enhanced Care Management (ECM) and In Lieu of Services (ILOS) for public comment. The documents include the DHCS/Managed Care Plan ECM and ILOS Contract Template; ECM and ILOS Standard Provider Terms and Conditions; ECM and ILOS Model of Care Template; and ECM and ILOS Coding Guidance. CalOptima staff will review the material for its impact on the organization. In March, CalOptima will begin

our collaboration with health networks to discuss the CalAIM initiatives. ECM and ILOS have a proposed effective date of January 1, 2022.

CalOptima Distributes $209 Million in Hospital Quality Assurance Fee (HQAF) Payments
On February 19, CalOptima released $209 million in HQAF funding to 26 hospitals. The payments cover the 18-month period of July 2019–December 2020. The HQAF program provides supplemental payments to California hospitals that serve Medi-Cal and uninsured patients, and CalOptima passes through the funding to the hospitals according to instructions from the California Hospital Association.

CalOptima Engages Elected Officials at Virtual Events
Since travel to Washington, D.C., is limited, the Association for Community Affiliated Plans is hosting a Virtual Legislative Fly-In February 24–26. Along with Executive Director of Public Affairs Rachel Selleck, I have several online meetings scheduled with federal elected officials and/or their staffs. Meetings are set with Reps. Lou Correa, Mike Levin and Alan Lowenthal, and the staffs of Sen. Alex Padilla and Reps. Katie Porter and Young Kim. We will share details about CalOptima's work to serve members during the pandemic and request legislative support in certain areas. Separately, CalOptima will host a Virtual Legislative Update on March 12 for our local, state and federal delegation and their staffs. Via webinar, CalOptima will highlight our legislative priorities and issues that impact members, such as COVID-19 vaccine distribution.

Joint Advisory Committee Meeting to Consider Key Issues, Strategic Plan Priorities
CalOptima's four advisory committees—Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee—will come together on March 11 to address interests shared by all committees. Topics include COVID-19 in older adults, health network contracting, CalAIM, and federal and state legislative information. In addition, staff plans to engage the group to gather feedback about increasing the attention on health equity, behavioral health, social determinants of health and service delivery models within the CalOptima 2020–2022 Strategic Plan. Staff will share the outcome of this discussion with the Board and seek guidance about how to enhance the Strategic Plan going forward.

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CalOptima

Better. Together.

COVID-19 Update

Board of Directors Meeting
March 4, 2021

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

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COVID-19 Efforts in Progress

- Member Incentive Implementation
  - Number of vaccinated members
  - Incentive strategy for members experiencing homelessness
  - Member outreach (mailing, website, etc.)

- Member Vaccination Strategy
  - Vaccine delays
  - Blue Shield to oversee an equitable vaccine distribution plan

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CalOptima
A Public Agency

Our Mission

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

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CalOptima
A Public Agency

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 4, 2021

A Regular Meeting of the CalOptima Board of Directors was held on February 4, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:05 p.m. and led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Supervisor Doug Chaffee (left meeting at 3:00 p.m.); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Scott Schoeffel; Trieu Tran, M.D.
(All Board Members participated remotely except Andrew Do, Chair, who attended in person)

Members Absent: Clayton Chau, M.D. (non-voting)

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

PRESENTATIONS/INTRODUCTIONS

None.

Chairman Do reordered the agenda to hear the Report Items before the Consent Calendar for quorum management purposes.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, highlighted several items from his report. Since the Board last met, there is a new administration in the White House with the election of President Joe Biden and we are waiting to see how changes in the administration will impact the Centers for Medicaid & Medicare Services (CMS), the Department of Health Care Services (DHCS), as well as CalOptima. Initially we have seen increased funding for COVID-19 vaccines and testing as well as personal protection equipment (PPE). Mr. Sanchez noted the grand opening of the BeWell OC, which CalOptima, the County, and others collaborated on to make this state-of-the-art facility become a reality. He also commented on the success of the PACE vaccination event and many of CalOptima's PACE participants expressed their gratitude to be able to receive these life-saving vaccinations.

2. COVID-19 Update

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

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PUBLIC COMMENTS
There were no requests for public comment.

REPORTS
18. Consider Actions Related to Implementation of CalOptima's COVID-19 Vaccine Strategy
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Chau did not participate in this item due to his role as Director of the Orange County Health Care Agency.

Dr. Fonda introduced the item and provided an update on CalOptima's and the Orange County Health Care Agency's collaboration to encourage CalOptima members to get vaccinated as additional doses become available.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors 1.) Authorized participation in the County of Orange's COVID-19 Vaccine Equity Pilot Program, and coordination with the Orange County Health Care Agency for implementation of a portion of CalOptima's COVID-19 Member Vaccine Incentive Program; 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract or contract amendments, and data sharing arrangement with the County of Orange as appropriate, subject to regulatory approvals as necessary for distribution of CalOptima's COVID-19 member incentive; and 3.) Authorize the Chief Executive Officer to coordinate with the County of Orange and other CalVax authorized providers to organize vaccination events for CalOptima Members, and with the assistance of Legal Counsel, to enter into any necessary contracts or contract amendments with those providers. (Motion carried 7-0-0; Director Schoeffel absent)***

19. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers for Mitigation of COVID-19-Related Expense
This item was continued to a future meeting due to lack of a quorum.

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expense
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act and passed the gavel to Vice Chair Becerra. Director Jordan did not participate in the discussion and vote due to his role as Chief Operating Officer at Providence/St. Joseph. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors: 1.) Authorized a temporary, short-term supplemental payment increase of 5% from current levels, for compliant contracted CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided on dates of service***

January 1, 2021 through June 30, 2021; 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend contracts with Long Term Acute Care Hospitals (LTAC) to increase compensation for authorized inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 Public Health Emergency (PHE). The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021; and 3.) Authorized unbudgeted expenditures up to $5.0 million to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals. (Motion carried 5-0-1; Chairman Do abstained, Directors Jordan and Schoeffel absent)

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

Vice Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors, 1.) Authorized a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and 2.) Authorized unbudgeted expenditures up to $210,000 to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers. (Motion carried 6-0-0; Vice Chair Becerra and Director Schoeffel absent)***

22. Consider Reallocation of Intergovernmental Transfer (IGT) 9 Funds Allocated for Virtual Urgent Care (eVisit) to Support both eVisit and eConsult Implementation During Coronavirus (COVID-19) Pandemic and Beyond

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

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors, reallocated $2 million in Intergovernmental Transfer (IGT) 9 funds previously allocated for the virtual urgent care (eVisit) project to support both the eVisit and eConsult projects for CalOptima Direct, including CalOptima Community Network (COD/CCN) members and providers, during and after the COVID-19 pandemic. (Motion carried 7-0-0; Director Schoeffel absent)***

23. Consider Ratifying Amendments to the Medi-Cal Shared-Risk Physician Group, Physician Hospital Consortium, and Health Maintenance Organization Health Network Contracts, Except Kaiser Foundation Health Plan, Inc.

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Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act and passed the gavel to Vice Chair Becerra. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors, ratified amendments to the Health Network contracts for Medi-Cal Shared-Risk Physician Group (SRG), Physician Hospital Consortium (PHC), and Health Maintenance Organization (HMO) Health Networks, except Kaiser Foundation Health Plan, Inc., to: 1.) Revise Whole Child Model (WCM) capitation rates; 2.) Extend funding and revise reimbursement rates for Health Homes Program (HHP); and 3.) Incorporate language changes including operational requirements. (Motion carried 6-0-1; Chairman Do abstained; Director Schoeffel absent)***

CONSENT CALENDAR

3. Minutes
   a. Approve Minutes of the December 3, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Approve Minutes of the January 7, 2021 Special Meeting of the CalOptima Board of Directors

4. Consider Approval of Modifications to Policy GG.1643: Minimum Physician Standards

5. Consider Ratification of Modifications to CalOptima Policy and Procedure GG.1352 Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21

6. Consider Authorizing Modification and Extension of License Agreement with the County of Orange for Use of Space at the Orange County Community Service Center Annex
Director Schoeffel did not participate in this item due to potential conflicts of interest.

7. Consider Authorization of Contract with Legislative Tracking Services Vendor and Proposed Budget Reallocation of Fiscal Year 2020–21 Operating Budget Funds

8. Consider Approval of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

9. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services Related to Rate Changes

10. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Bridge Period Contract Amendment

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11. Consider Selection and Award of Contract for Vision Services Vendor

12. Consider Authorizing an Amendment to Extend the Program of All-Inclusive Care for the Elderly (PACE) Contract with Mediture for Electronic Health Record Services

13. Consider Ratification of an Enterprise Agreement with Dell Corporation for Access to Microsoft Products
Director Schoeffel did not participate in this item due to potential conflicts of interest.

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

15. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates
This item was pulled for discussion.

16. Consider Authorizing Extension of Federal Legislative Advocacy Services Contract with Akin Gump Straus Hauer & Feld LLP
Chairman Do amended the motion on Agenda Item 16 to extend the contract for three months instead of one month commencing February 21, 2021, to allow the Federal Lobbyist Board Ad Hoc additional time to evaluate the finalists.

17. Receive and File
a. November and December 2020 Financial Summaries
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Director Schoeffel did not participate in Consent Calendar Agenda Items 6, 13, and 15 due to potential conflicts of interest.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors approved Consent Calendar Items 3 through 17, minus Consent Calendar Item 15, with the correction noted for Consent Calendar Agenda Item 16, as presented. (Motion carried 6-0-0 except as noted; Supervisor Chaffee and Director Schoeffel absent)***

15. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates
Director Schoeffel did not participate in this item due to potential conflicts of interest.

After considerable discussion, the Board directed staff to provide the Board with a side-by-side comparison of key points in the Kaiser contract and other CalOptima health network contracts to ensure all networks are treated in an equitable manner.

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CEO Sanchez noted that the recommended extension of the Kaiser contract through June 30, 2021, would bring it into alignment with the next round of amendments for all health network contracts. He also noted that he is happy to provide the Board with any additional information or answer any questions with regard to the status of the Kaiser contract negotiation.

Action: ***On motion od Director Giammona, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to execute: 1.) An Amended and Restated Medi-Cal Health Network Contract with Kaiser Foundation Health Plan, Inc., incorporating language changes, effective July 1, 2019 through June 30, 2021; and 2.) Amendments incorporating all changes made in the Health Network contracts since July 1, 2019, including certain operational requirements and revisions to the capitation rates. (Motion carried 6-0-0; Supervisor Chaffee and Director Schoeffel absent)***

ADVISORY COMMITTEE UPDATES

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

Junie Lazo-Pearson, Ph.D., Provider Advisory Committee Chair, provided an update on the recent Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee activities.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board Members thanked the County, the provider community, and CalOptima for moving quickly to ensure CalOptima members are vaccinated.

Chairman Do announce the formation of a System Delivery Board Ad Hoc Committee and Directors Giammona and Jordan agreed to serve on this ad hoc, along with Chairman Do.

Chairman Do directed staff to bring a draft Strategic Plan back to the Board for consideration. He noted that staff should focus on: 1) equity; 2) behavioral health; 3) social determinates of health (SDOH); and 4) service delivery model. Chairman Do also directed staff to solicit input from the CalOptima's Member Advisory Committee (MAC) and Provider Advisory Committee (PAC), prior to bringing the draft back to the Board.

In addition, Chairman Do directed staff to explore the possibility of adding a dedicated Homeless Health Services Manager/Director in the CalOptima Population Health Management Department.

CLOSED SESSION

The Board of Directors adjourned to closed session at 3:29 p.m. pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Kindred Hospital – Westminster and Kindred Hospital – Santa Ana, et al. v. CalOptima et al. (Orange County Superior Court Case No.: 30-2020-01140494-CU-BC-CJC)

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ADJOURNMENT
The meeting was adjourned at 4:02 p.m. with no reportable action taken in the Closed Session.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 4, 2021

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
FINANCE AND AUDIT COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 19, 2020

A Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on November 19, 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.

CALL TO ORDER
Chair Isabel Becerra called the meeting to order at 2:04 p.m. Director Corwin led the Pledge of Allegiance.

Members Present: Isabel Becerra, Chair; Clayton Corwin; Scott Schoeffel (all Members at teleconference locations)

Members Absent: None

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

PUBLIC COMMENTS
There were no requests for public comment.

MANAGEMENT REPORTS
1. Chief Financial Officer Report
Nancy Huang, Chief Financial Officer, provided three high-level updates. The first was that the Department of the Health Care Services (DHCS) has announced the delay of the Medi-Cal Pharmacy Carve-out (Medi-Cal Rx), which will occur no earlier than April 1, 2021. The second was related to the DHCS rate schedule release. CalOptima received draft Medi-Cal Classic and Expansion rates at the end of September. As part of the rate release, DHCS notified CalOptima that it had granted a glide-path on the Medi-Cal Expansion rates. The DHCS did not implement the full reduction in the coming year, which will allow additional time for CalOptima and its providers to make necessary operational changes related to the future reductions. In late October, CalOptima received updated rates for the Health Homes Program and Whole-Child Model program, and last Monday, DHCS also released t CCI rates for CalOptima's Medi-Medi dual-eligible population. Those rates are draft and subject final adjustments

based on factors such as population acuity and plan efficiency, as well as miscellaneous COVID-19 adjustments. Staff is evaluating the overall budget impact, and the preliminary analysis of the draft rates received is that they are tracking very closely with CalOptima's fiscal year 2021 budget assumptions. The third update is on the Coordinated Care Initiative (CCI) data reconciliation. Ms. Huang noted that in July of 2020, DHCS identified a system logic error during its processing of the CCI indicator file for managed care plans. The logic error affects the institutional and Home and Community-Based Services (HCBS) members in the Cal MediConnect (CMC) program. The logic error has been occurring since the implementation date of the CMC program in 2015. DHCS has acknowledged that this issue is complex and will work directly with individual health plans on the reconciliation details.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period July 1, 2020 through September 30, 2020. As reported to the Board of Directors' Investment Advisory Committee, she noted that all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy during that period.

CONSENT CALENDAR

3. Approve the Minutes of the September 17, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the July 20, 2020 Regular Meeting of the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Corwin, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)***

Chair Becerra reordered the agenda to hear Agenda Item 10, before Agenda Item 4 due to its relevance to Agenda Item 4.

INFORMATION ITEM

10. Investment Advisory Committee Overview

Patrick Moore, Chair, CalOptima Investment Advisory Committee (IAC), presented the Finance and Audit Committee (FAC) with an introduction to the IAC, and answered Committee member questions.

REPORTS

4. Consider Recommending Board of Directors' Approval of Proposed Changes to CalOptima Policy GA. 3400: Annual Investments

Ms. Huang introduced the item.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors approve the proposed changes to CalOptima Policy GA. 3400: Annual Investments. (Motion carried 3-0-0)***

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5. Consider Recommending that the Board of Directors' Authorize an Amendment to the Amended and Restated Development Agreement with the City of Orange to Extend CalOptima's Development Rights
Staff noted a correction to the date in the first recommended action, which should be October 28, 2026, instead of October 23, 2026.

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors: 1.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Amended and Restated Development Agreement with the City of Orange to extend its term for up to six (6) additional years, through October ~~23~~ 28, 2026, contingent upon approval of the Orange City Council; and 2.) Authorize unbudgeted expenditures in an amount up to $105,000 from existing reserves for fees associated with the amendment through June 30, 2021, with correction noted. (Motion carried 2-0-0; Director Schoeffel absent)*** *Rev. 11/19/20*

6. Consider Recommending that the Board of Directors' Approval of Proposed Revisions to CalOptima's Operations Policies and Procedures

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommend that the Board of Directors: 1) Approve modification of the following policies and procedures in connection with CalOptima's regular review process: a.) DD.2013: Customer Services Grievance Process b.) FF.2003: Coordination of Benefits c). FF.2005: Conlan, Member Reimbursement d.) FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Members when Health Networks are Financially Responsible for the Qualifying Services e.) FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services, and f.) MA.3101: Claims Processing; and 2) Authorize Staff to further update Attachment A of Policies FF.2011 and FF.2012 for the continuation of payment of Directed Payments to eligible non-contracted providers for qualifying non-contracted Ground Emergency Medical Transport (GEMT) services for State Fiscal Year (SFY) 2020-2021 with dates of services between July 1, 2020 and June 30, 2021, upon receipt of and pursuant to DHCS's written instruction to CalOptima prior to the release of DHCS final guidance, with any further changes to Attachment A remaining subject to Board approval. (Motion carried 3-0-0)***

7. Consider Recommending Board of Directors' Authorization for the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services

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Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors: 1.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Advanced Medical Reviews (AMR) to expand the scope of work to include the provision of the following services: a.) Retro claims review to ensure medical services are billed appropriately; b.) Review of Grievance and Appeal cases to ensure same or similar specialty review; c.) Review of Behavioral Health cases; and d.) Review of Fraud, Waste and Abuse cases. 2.) Authorize reallocation of budgeted but unused funds to support the expanded scope of services for AMR through June 30, 2021: a.) Up to $28,000 from Medical Management – Salaries to Medical Management – Professional Fees; and b.) Up to $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees; and 3.) Authorize reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees and to extend the contract with medical consultant, Peter Scheid, M.D., to assist with Potential Quality Issue (PQI) cases through June 30, 2021 (Motion carried 2-0-0; Director Schoeffel absent)***

8. Consider Recommending Board of Directors' Approval of Actions Authorizing Extensions and Other Modifications for Whole Person Care Agreements with the Orange County Health Care Agency
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Candice Gomez, Executive Director, Business Implementation, introduced the item, noting that the extension request for the Whole Person Care (WPC) Administrative Services Agreement and the WPC Grant Agreement for Recuperative Care Services with the Orange County Health Care Agency (HCA) is due to CalAIM being postponed due to the COVID-19 pandemic. The state is asking the federal government for an extension of the WPC program until the end of 2021. Ms. Gomez noted that with the extension of the WPC, CalOptima and HCA were equally splitting the cost of recuperative care services for qualifying CalOptima members. CalOptima was using pre-IGT 8 dollars to fund its fifty percent of the recuperative care costs. Ms. Gomez noted that the available IGT dollars funding recuperative care services could be exhausted as early as April 2021.

Ms. Gomez explained that the IGT funds received after IGT 7 (i.e., IGT 8, 9, 10, and any future IGT payments) could not be used for this purpose as they are categorized by the state as part of the capitation payments CalOptima receives, and their use is limited to Medi-Cal covered benefits. Mr. Sanchez added that CalOptima has reached out to the state to ask whether these funds could be used for "in lieu of services."

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors, contingent on extension of the Whole Person Care (WPC) pilot in the Medi-Cal 2020 Waiver authorize the Chief Executive Officer (CEO), with assistance of legal counsel, to extend and***

amend the following agreements with the Orange County Health Care Agency (OCHCA) consistent with the WPC extension(s) granted: 1.) WPC Administrative Services Agreement; and 2.) WPC Grant Agreement for Recuperative Care Services. (Motion carried 2-0-0; Director Schoeffel absent)

9. Consider Recommending Board of Directors' Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020-2021 Capital Budget
Ladan Khamseh, Chief Operating Officer, introduced the item.

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors authorize reallocation of budgeted but unused funds in the amount of up to $430,000 from the Network – Wireless System Upgrade project to fund the Telephony – Upgrade Contact Center project through June 30, 2021. (Motion carried 2-0-0; Director Schoeffel absent)***

INFORMATION ITEMS
Chair Becerra had reordered the agenda to hear Agenda Item 10 prior to Agenda Item 4

11. Overview of the Office of Compliance
Silver Ho, Executive Director, Compliance, provided an overview of the Office of Compliance and answered Committee member questions. Ms. Ho reviewed the internal structure of the Office of Compliance, CalOptima's audit and oversight activities, both internally and externally, and independent internal audits. Ms. Ho noted that CalOptima is also subject to regulatory audits from the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

12. DHCS Medical Audit Corrective Action Plan Status
TC Roady, Director, Regulatory Affairs & Compliance (Medi-Cal), provided an update on the status of CalOptima's corrective action plan response to the Department of Health Care Services (DHCS) Medical Audit, which resulted in seven findings.

The following Information Items were accepted as presented.

13. September 2020 Financial Summary
14. CalOptima Information Security Update
15. Quarterly Operating and Capital Budget Update
16. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Health Homes Financial Report
    d. Reinsurance Report
    e. Health Network Financial Report
    f. Contingency Contract Report

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COMMITTEE MEMBER COMMENTS

Committee members thanked one another and recognized staff for the work that went into preparing for the meeting, and that they looked forward to future meetings.

CLOSED SESSION

The Finance and Audit Committee adjourned to closed session at 3:49 p.m. pursuant to Government Code section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATIORS Property: 13300 Garden Grove Blvd., Garden Grove, CA 92843 Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank Negotiating Parties: Young S. Kim and Soon Y. Kim Under Negotiation: Price and Terms of Payment

The Finance and Audit Committee reconvened to open session at 4:50 p.m. with no reportable action taken.

ADJOURNMENT

With no further business, the Finance and Audit Committee meeting was adjourned at 4:51 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 18, 2021

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MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 10, 2020

A Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on December 10, 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.

CALL TO ORDER
Chair Mary Giammona, M.D., called the meeting to order at 3:00 p.m. and Dr. Emily Fonda, led the Pledge of Allegiance.

Members Present: Mary Giammona, M.D., Chair; Trieu Tran, M.D. (via teleconference)

Members Absent: None

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel, Betsy Ha, Executive Director, Quality and Population Health Management; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D., Acting Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Medical Officer Update

Emily Fonda, M.D., Acting Chief Medical Officer, reviewed the latest COVID-19 numbers, and reported that, as of December 9, 2020, Orange County had 93,126 positive cases, and of those, 4,237 are CalOptima members. The deaths from COVID-19 in Orange County total 1,633, and 341 were CalOptima members. A total of 974 COVID-19 patients are currently in hospitals in Orange County and of those, 239 are in Intensive Care. Dr. Fonda also reported that, according to the California Department of Public Health (CDPH), the Orange County Health Care Agency (OCHCA) is to receive 25,350 doses of the Pfizer-manufactured COVID-19 vaccine next week. Following the CDPH's Community Vaccine Advisory Committee recommended multi-phased approach, the OCHCA will distribute the initial vaccine supply to Orange County hospitals, with high-risk health care workers prioritized to receive the vaccine as part of Phase 1a.

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CONSENT CALENDAR

2. Approve the Minutes of the September 16, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Tran, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0)***

REPORTS

3. Consider Recommending Board of Directors' Approval of Modifications to Policy GG. 1643: Minimum Physician Standards

Betsy Ha, Executive Director, Quality and Population Health Management introduced the item.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors' approval of Modifications to Policy GG. 1643: Minimum Physician Standards pursuant to CalOptima's regular review process. (Motion carried 2-0-0)***

INFORMATION ITEMS

4. Behavioral Health Interventions During COVID-19 Pandemic

Edwin Poon, Ph.D., Director, Behavioral Health Services, provided an update on CalOptima's behavioral health interventions during the COVID-19 pandemic. Dr. Poon noted that many CalOptima members have experienced an increase in depression and anxiety since the beginning for the pandemic.

5. Access and Availability Report

Marsha Choo, Manager, Quality Analytics, provided an overview of CalOptima's access and availability reports for adults and children. Ms. Choo noted that the reports are based, in part, on a member experience survey, known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS). These reports provide an overall indicator of member satisfaction with many measures, including "getting care quickly" and "access to nearby care," helping CalOptima staff to identify areas for improvement. CalOptima also implemented a mystery shopper program, where a vendor calls providers' offices and asks for appointments to measure lead time for accessing care. Ms. Choo noted that CalOptima's regulators, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS) set member satisfaction benchmarks for all plans for these measures. Based on the results of the CAHPS survey, CalOptima is evaluated and ranked by regulators, and identifies areas for improvement.

6. Population Health Equity Analysis

Ms. Ha provided an overview of CalOptima's population health equity analysis and Marie Jeannis, Director, Enterprise Analytics provided additional details on health disparities across ethnic groups.

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7. Trauma-Informed Care and ACEs Aware Update
Ms. Ha presented an update on trauma-informed care and CalOptima's ACEs aware initiatives.

8. National Committee for Quality Assurance Accreditation Preparedness Update
Esther Okajima, Director, Quality Improvement, provided an update on CalOptima's work to prepare for the upcoming National Committee for Quality Assurance Accreditation renewals survey for 2020.

9. 2020 Quality Improvement Program Preliminary Evaluation
Ms. Ha provided a brief overview of the Quality Improvement Program for 2020. Staff expects to present the 2020 Quality Improvement Program evaluation at the February Quality Assurance Committee (QAC) along with the draft plan for Calendar Year 2021.

The following Information Items were accepted as presented:
10. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
11. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Committee Report
    b. Program of All-Inclusive Care for the Elderly (PACE) Report
    c. Member Trend Report

COMMITTEE MEMBER COMMENTS
The Committee members thanked staff for their work and wished everyone a happy holiday season.

ADJOURNMENT
Hearing no further business, Chair Giammona adjourned the meeting at 5:00 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 25, 2021

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

October 27, 2020

A Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee (WCM FAC) was held on October 27, 2020, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Kristen Rogers, WCM FAC Chair called the meeting to order at 9:37 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Kristen Rogers, Chair; Brenda Deeley, Vice Chair; Maura Byron; Cathleen Collins; Jacqui Knudsen; Monica Maier; Malissa Watson

Members Absent: Sandra Cortez-Schultz; Kathleen Lear

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operations Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Deputy Chief Medical Officer; Belinda Abeyta, Executive Director, Operations; Betsy Ha, Executive Director, Quality and Population Health Management; Candice Gomez, Executive Director, Program Implementation; Tracy Hitzeman, Executive Director, Clinical Operation; Thanh-Tam Nguyen, M.D., Medical Director; Kris Gericke, Director, Pharmacy Management; Albert Cardenas, Director, Customer Service; Andrew Tse, Associate Director, Customer Service; Vy Nguyen, Manager, Customer Service; Jackie Mark, Sr. Policy Advisor, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Praveena Lal, Administration Assistant, Customer Service

MINUTES

Approve the Minutes of the August 27, 2020 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Byron, seconded and carried, the WCM FAC Committee approved the minutes of the August 27, 2020 meeting. (Motion carried 7-0-0; Members Sandra Cortez-Schultz and Kathleen Lear absent)***

PUBLIC COMMENT

There were no public comments

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer, updated the committee on the possibility of a Medi-Cal Expansion rate reduction that had been announced by the Department of Health Care Services (DHCS) in September. He noted that recently DHCS had notified CalOptima that the Medi-Cal Expansion rate cuts would not be as large as anticipated and that DHCS had agreed to work with CalOptima on the requested glidepath for these rate reductions. Mr. Sanchez also informed the committee that CalOptima had recently been recognized by the DHCS for meeting quality metrics set by the State and that CalOptima was the only plan in California to meet all of the established metrics.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer mentioned that in general the Whole Child Model program has gone really well and how CalOptima was still working to make it even better. He noted that the Clinical Advisory Committee had been working on a number of areas but noted that it has been a successful partnership and collaboration.

INFORMATION ITEMS

Whole-Child Model Member Updates

Chair Rogers reminded the members that there were still two Authorized Family Member seats available and asked for help with recruitment for these seats. Chair Rogers also announced that there would be a Joint Meeting on December 10, 2020 for all the Board Advisory Committees and that more information would be sent out closer to the date. She also reminded the members that the next Whole Child Model Family Advisory Committee meeting will be held on February 23, 2021 as the December meeting had been cancelled due to the joint meeting. Chair Rogers also reminded the members to please complete their mandatory compliance courses if they had not already done so as the November 6, 2020 deadline was fast approaching.

California Children Services Advisory Group Update

Tracy Hitzeman, Executive Director, Clinical Operations, provided verbal update on DHCS's California Children Services Advisory Group (CCS AG) meeting. Ms. Hitzeman noted that they were presented with an updated draft of the Whole-Child Model (WCM) dashboard and were advised that the CCS classic dashboard was not ready and that the CalOptima and the other Plans were looking forward to when this is released for review. She also noted that an update was provided on Medical Therapy Unit (MTU) guidance during COVID-19 which added the ability for children who needed to be seen at the MTU for critical or urgent needs. Specific criteria have been outlined and this information can found on the DHCS website.

California Children Services Aging Out Transition

Tracy Hitzeman also provided a verbal update on the transition of care for WCM members who were approaching age 21 and who would be aging out of CCS and transitioning to full-scope Medi-Cal. She noted that the goal was to provide education and initiate planning with the member/family

member's for future health care and other life issues. This would also involve working with the primary care physician and others involved to smoothly transfer care to adult providers from pediatric providers.

Medi-Cal Rx Update

Kristin Gericke Pharm.D, Director, Pharmacy Management provided a verbal update on the Medi-Cal Rx transition to Magellan Health Care which is slated to be effective on January 1, 2021. Dr. Gericke noted that 30, 60 and 90 day notices have begun with CalOptima responsible for the 30-day notice to the members.

Federal and State Legislative Update

Jackie Mark, Sr. Policy Advisor, Government Affairs provided a verbal update on the Federal and State legislative agenda and advised that September 30, 2020 had been the deadline date for Governor Newsom to sign or veto legislation. Ms. Mark also discussed Assembly Bill (AB) 2276 which relates to childhood blood lead screening tests and accessibility to get tested. She also discussed the delay being experienced in passing the next COVID relief bill due to the upcoming election.

ADJOURNMENT

Chair Rogers reminded the committee members that the next meeting would be a joint meeting on December 10, 2020 at 8:00 a.m.

Hearing no further business, Chair Rogers adjourned the meeting at 10:44 a.m.

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

Approved: February 23, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Nancy Huang, Chief Financial Officer & Treasurer, (657) 235-6935

Recommended Actions

Recommend reappointment of Patrick Moore:

1. To the Investment Advisory Committee (IAC) for a two-year term effective March 7, 2021; and
2. To serve as Chair of the IAC, for a two-year term beginning March 7, 2021, or until a successor is appointed.

Background

At its September 10, 1996 Special Meeting, the CalOptima Board of Directors authorized the creation of the IAC, established qualifications for committee membership, and directed staff to proceed with the recruitment of the volunteer members of the IAC.

When creating the IAC, the Board stipulated that it would be comprised of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents possessing experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board expanded the size of the IAC from five (5) members to seven (7) members in order to include more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion

The candidate recommended for reappointment, Patrick Moore, has consistently provided leadership and service to CalOptima through his long-time participation as an IAC member and chairman.

Mr. Moore, an attorney, represented health care provider clients for 40 years before retiring in 2018. He started his own firm, Patrick K. Moore Law Corporation, in March 2001. Prior to that, he was in-house counsel for the University of California and a partner at several law firms with significant health care practices. Mr. Moore now serves as an arbitrator, mediator and expert witness in health care disputes. He holds preeminent A/V peer review rating in the Martindale-Hubbell Law Directory.

Mr. Moore has served as director of the California Society for Healthcare Attorneys, the UCI Foundation (Executive and Finance Committees), Laguna Playhouse and Anaheim Memorial Medical Center (Finance and Audit Committees). He also was a member of the Audit Committee of Memorial Health Services.

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Mr. Moore began serving as a member of the IAC when it was initiated in November 1996. From 2000 to 2002, he did not serve on the IAC due to his being a partner at Foley & Lardner, which at the time was CalOptima's counsel. He returned to the IAC in January 2002 and has served continuously since that time. His current term expires on March 6, 2021.

At its January 25, 2021, meeting, the IAC recommended that the Finance and Audit Committee recommend that the Board reappoint Patrick Moore to the IAC and to serve as the Chair of the IAC.

Fiscal Impact
There is no fiscal impact. An individual appointed to the IAC assists CalOptima in suggesting updates to and ensuring compliance with CalOptima's Board-approved Annual Investment Policy, and to monitor the performance of CalOptima's investments, investment advisor and investment managers.

Rationale for Recommendation
The individual recommended for CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidate has long provided outstanding service as a member and chairman of the IAC.

Concurrence
Board of Directors' Finance and Audit Committee
Board of Directors' Investment Advisory Committee
Gary Crockett, Chief Counsel

Attachment
None

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Item

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

Contacts

Belinda Abeyta, Executive Director, Operations, (657) 235-6755
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Action

The CalOptima Member Advisory Committee recommends:

Appointment of the following individual to serve a two-year term on the Member Advisory Committee, effective March 4, 2021:

- Linda Adair Pugh to serve as the Medi-Cal Beneficiaries Representative for a term ending June 30, 2023

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. Pursuant to the resolution, the CalOptima Board appoints each member of the MAC for a two-year term, except for two standing seats: the County of Orange Social Services Agency representative and the Orange County Health Care Agency representative, which have unlimited terms. The CalOptima Board is responsible for the appointment of all MAC members. The Medi-Cal Beneficiaries Representative seat has been vacant since June 30, 2020 as the previous occupant Patty Mouton applied and was appointed July 1, 2020 as the Long-Term Services and Supports Representative.

Discussion

As part of the process of filling this vacancy, Staff conducted a comprehensive outreach beginning on March 1, 2020, including sending notifications to community-based organizations (CBOs), conducting targeted community outreach to agencies serving Medi-Cal members, as well as posting recruitment materials on the CalOptima website. Based on this outreach process, staff received one applicant for the Medi-Cal Beneficiaries seat.

The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Maura Byron, Steve Thronson and Christine Tolbert, met via conference call on January 28, 2021, to evaluate the application. Based on this evaluation process, the MAC Nominations Ad Hoc Subcommittee recommended the proposed candidate be forwarded to the MAC for consideration.

At the February 11, 2021, MAC meeting, MAC members accepted the recommended candidate as proposed by the Nominations Ad Hoc Subcommittee and requested that the proposed candidate be forwarded to the CalOptima Board for consideration.

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Candidate for the Medi-Cal Beneficiaries Representative position is as follow:

Medi-Cal Beneficiaries Representative Candidate
Linda Adair Pugh

Linda Adair Pugh is retired and a current CalOptima Medi-Cal member. Ms. Adair Pugh has lived in the Orange County area for more than 50 years and she currently sits on two different boards for the City of Anaheim: she serves on the Residential Advisory Board and is also a Commissioner on the Housing and Community Development Commission.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc Subcommittee's recommended candidate and concurred with the recommendation of the candidate. The MAC forwards the recommended candidate to the Board of Directors for consideration.

Concurrence
Member Advisory Committee Nominations Ad Hoc Subcommittee
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
6. Consider Authorizing Modifications to CalOptima Operations Policies and Procedures

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Belinda Abeyta, Executive Director, Operations, (657) 235-6755

Recommended Actions:
Recommend authorizing modifications to the following policies and procedures:
1. CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification
2. MA.4010: Health Network and Primary Care Provider Selection, Assignment and Notification

Background/Discussion
CalOptima staff regularly reviews the organization's policies and procedures to ensure that they are current and aligned with Federal and State health care program requirements, contract obligations, and laws, as well as CalOptima operations.

Modification to CalOptima Policies. Proposed policy modifications are summarized below:

1. ***CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification*** defines the criteria guiding CalOptima's OneCare Connect process for member selection of or assignment to a Health Network and Primary Care Provider (PCP), and the notification to a OneCare Connect member of a PCP contract termination. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Proposed revisions include modifying definitions; adding requirements for member selection of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC); adding references to other relevant policies, including *CMC.4003: Member Enrollment (Voluntary)* and *CMC.4011: Notice of Change in Location and Availability of Covered Services*; and removing references to policies that are no longer applicable, including *CMC.1207a: Member Auto Assignment, CMC.4003: Member Enrollment* and *CMC.4011: Notice of Change in Location and Availability of Covered Services.*

2. ***MA.4010: Health Network and Primary Care Provider Selection, Assignment and Notification*** defines the criteria guiding CalOptima's OneCare process for member selection of or assignment to a Health Network and Primary Care Provider (PCP), and the notification to a OneCare Connect member of a PCP contract termination. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Proposed revisions include modifying definitions and adding requirements for member selection of a Federally Qualified Health Center or Rural Health Clinic.

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Fiscal Impact
The recommended action to approve revisions to CalOptima Policies CMC.4010 and MA.4010 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020–21 Operating Budget approved by the Board on June 4, 2020.

Rational for Recommendation
Reflecting CalOptima's commitment to operating in compliance with all applicable requirements, staff recommends that the Board approve and adopt the proposed updates to the aforementioned CalOptima policies and procedures, which will supersede prior versions.

Concurrence
Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments
1. CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification
2. MA.4010: Health Network and Primary Care Provider Selection Assignment and Notification
3. CMC.4003: Member Enrollment (Voluntary)
4. CMC.4011: Notice of Change in Location and Availability of Covered Services

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

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Policy:	CMC.4010
Title:	**Health Network and Primary Care Provider Selection, Assignment, and Notification**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	05/01/2015
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the CalOptima OneCare Connect process for Member selection of, or assignment to, a Health Network and Primary Care Provider (PCP), and the notification to a OneCare Connect Member of a PCP or Health Network contract termination.

II. POLICY

A. CalOptima is committed to a Member's right to select a Health Network and a PCP.

B. CalOptima shall ask each individual who voluntarily enrolls into OneCare Connect to select a Health Network and a PCP from the OneCare Connect Provider directory, prior to the Member's effective date of OneCare Connect coverage.

C. A Member may only select a PCP within their selected Health Network.

D. A OneCare Connect Member may select a specialist Provider as a PCP, within their selected Health Network, so long as the specialist Provider is willing to perform the role of the PCP and the specialist Provider is set up in OneCare Connect systems as a PCP and is open and available to Members.

E. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

~~E.~~F. If a Member fails to select a Health Network and a PCP prior to the Member's enrollment effective date, CalOptima shall assign such Member to a Health Network and a PCP in accordance with the terms and conditions of this ~~policy, and in accordance with CalOptima Policy CMC.1207a: OneCare Connect Auto Assignment~~Policy.

~~F.~~G. CalOptima may assign a Member to a Health Network if CalOptima and Centers for Medicare & Medicaid (CMS) eligibility information indicate a Member is eligible, even if the eligibility

information received from the Department of Health Care Services (DHCS) does not indicate the Member is eligible. Any eligibility discrepancies requiring regulatory action shall be submitted to CMS and/or DHCS for resolution, as appropriate.

~~G.~~H. CalOptima shall notify a Member, in writing, of the Member's Health Network and PCP assignment, with instructions on how the Member may change their Health Network and/or PCP.

~~H.~~I. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima, in accordance with the terms and conditions of this policy and CalOptima Policy CMC.4011: Notice of Change in Location and Availability of Covered Services.

~~I.~~J. If a Member transitions to a Long-Term Care (LTC) facility or is identified as residing in an LTC facility after enrollment, the Member may be assigned to the CalOptima Community Network (CCN) in accordance this policy.

~~J.~~K. CalOptima shall notify affected Members of a PCP or Health Network contract termination, in accordance with the terms and conditions of this policy.

III. PROCEDURE

A. For voluntary enrollments, if an individual completes an enrollment application during a face-to-face or telephonic interview with a qualified OneCare Connect enrollment representative, the representative shall assist the prospective Member in selecting a Health Network and a PCP at the time of the interview and completion of the application.

B. If a Member submits the OneCare Connect enrollment application by mail or facsimile, CalOptima enrollment staff shall use ensure the selection of a Health Network and/or PCP as follows:

1. If the Member selected a PCP but failed to select a Health Network, CalOptima shall assign the Member to a Health Network as follows:

   a. If the Member's selected PCP contracts with only one (1) Health Network, CalOptima shall assign the Member to that Health Network.

   b. If the Member's selected PCP contracts with more than one (1) Health Network, CalOptima shall contact the Member to obtain the Member's choice of Health Network.

   c. If CalOptima's attempt to contact the Member is unsuccessful, CalOptima shall assign the Member to a Health Network that contracts with the selected PCP, taking into consideration the geographic concentration of available Providers in the Health Network(s) in relation to the location of the Member's residence.

2. If the Member selected a Health Network, but failed to select a PCP, CalOptima shall assign the Member to a PCP as follows:

   1. CalOptima shall contact the Member to obtain the Member's PCP selection.

   2. If CalOptima's attempt to contact the Member is unsuccessful, CalOptima shall assign the Member to a PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

3. If the Member selected a PCP who is not available to new Members, CalOptima shall assign the Member to another PCP as follows:

    a. CalOptima shall contact the Member to inform the Member that the selected PCP is not available to new Members, and obtain the Member's new PCP selection.

    b. If CalOptima's attempt to contact the Member is unsuccessful, CalOptima shall assign the Member to another PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

4. If the Member fails to select both a Health Network and a PCP, CalOptima shall assign the Member to a Health Network and PCP as follows:

    a. CalOptima shall contact the Member to obtain the Member's choice of Health Network and PCP.

    b. If CalOptima's attempt to contact the Member is unsuccessful , CalOptima shall assign the Member to a Health Network and PCP, taking into consideration the geographic location of the Member's residence and the Member's preferred language, if available.

C. A Member may request to change their Health Network and/or PCP every month. A Member, their conservator, or the Member's Legal ~~/Authorized~~ Representative shall contact the OneCare Connect Customer Service Department to request a Health Network and/or PCP change.

1. If the request to change the Health Network and/or PCP is received by CalOptima by close of business on the last business day of the month, the effective date with the new Health Network and/or PCP shall be the first (1st) calendar day of the immediately following calendar month.

2. If the request to change Health Network and/or PCP is received by OneCare Connect after the close of business on the last business day of the month, the effective date with the new Health Network and/or PCP shall be the first (1st) calendar day of the immediately following calendar month.

3. A Member may only select a PCP within their selected Health Network.

D. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima not later than sixty (60) calendar days prior to the PCP's contract termination date.

1. The Health Network(s) notice to CalOptima shall indicate an affected Member's new PCP assignment, the new PCP's name, and the new PCP's state license number, tax ID number, and NPI number (National Provider Identifier).

2. In the case of unforeseen circumstances (i.e., if the Health Network received less than sixty (60) calendar days notice from a PCP), the Health Network shall notify CalOptima of a PCP termination immediately upon receipt of such notice.

3. CalOptima shall make a good faith effort to notify an affected Member via telephone of a PCP termination no later than fifteen (15) calendar days after CalOptima receives notification from the Health Network or Provider. CalOptima's telephonic outreach to an affected Member shall include:

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a. A minimum of three (3) telephonic attempts to reach the Member

b. Provide the name and contact information of the Member's newly assigned PCP; and

c. Assist the Members in selecting a different PCP if they are not satisfied with their new PCP assignment.

E. Upon termination of a Health Network, CalOptima shall notify affected Members of a Health Network termination thirty (30) calendar days prior to the Health Network(s) contract termination date, or in the case of unforeseen circumstances, as soon as CalOptima receives notification from the Health Network.

1. CalOptima shall request the Members to select another Health Network.

2. If CalOptima is unable to contact a Member, or if the Member does not make a new Health Network selection prior to the end date of the terminating Health Network(s) contract, CalOptima shall assign the Member to an active Health Network contracted with the Member's current PCP.

3. If the Member's current PCP is not contracted with any other CalOptima Health Network, CalOptima shall assign the Member to a PCP and Health Network, taking into consideration the location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

F. Notwithstanding the above, if a Member:

1. Is known to reside in an LTC facility at enrollment, PCP and Health Network assignment shall ~~follow the logic described in CalOptima Policy CMC.1207a: OneCare Connect Auto Assignment.~~be to:

a. The LTC facility; and

b. The provider rendering services to the Member at the LTC facility.

2. Transitions to an LTC after enrollment in OneCare Connect or is identified later as residing in an LTC:

a. If the current PCP does not participate with CalOptima Community Network, the Member will remain assigned to that PCP and Health Network.

b. If the current PCP participates with CalOptima Community Network, the Member will be assigned to CalOptima Community Network and the same PCP.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. CalOptima Policy CMC.1207a: Member Auto Assignment~~
~~B. CalOptima Policy CMC.4003: Member Enrollment~~

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~~C.~~A. ~~CalOptima Policy CMC.4011: Notice of Change in Location and Availability of Covered Services~~
~~D.~~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
B. CalOptima Policy CMC.4003: Member Enrollment (Voluntary)
C. CalOptima Policy CMC.4011: Notice of Change in Location and Availability of Covered Services
~~E.~~D. Title 42, Code of Federal Regulations (CFR.), §422.111(e)
E. Welfare and Institutions Code §14087.325(b)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2013	Regular Meeting of the CalOptima Board of Directors
05/07/2015	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2015	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	12/01/2015	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	08/01/2016	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	08/01/2017	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	07/01/2018	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	09/01/2019	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
~~Revised~~	TBD	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect

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.
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.
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.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), 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.
Legal Representative~~/Authorized Representative~~	For the purposes of this policy, an individual who is the Legal Representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity. (Form CMS-1696 may not be used to appoint an Authorized Representative for the purposes of enrollment and disenrollment. This form is solely for use in the Claims Adjudication or Claim Appeals process, and does not provide broad legal authority to make another individual's healthcare decisions.)
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Member	A beneficiary enrolled in the CalOptima ~~An enrollee beneficiary of the~~ OneCare Connect program.
Primary Care Provider (PCP)	A physician who focuses their practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under Medicare.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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Policy:	CMC.4010
Title:	**Health Network and Primary Care Provider Selection, Assignment, and Notification**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	05/01/2015
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the CalOptima OneCare Connect process for Member selection of, or assignment to, a Health Network and Primary Care Provider (PCP), and the notification to a OneCare Connect Member of a PCP or Health Network contract termination.

II. POLICY

A. CalOptima is committed to a Member's right to select a Health Network and a PCP.

B. CalOptima shall ask each individual who voluntarily enrolls into OneCare Connect to select a Health Network and a PCP from the OneCare Connect Provider directory, prior to the Member's effective date of OneCare Connect coverage.

C. A Member may only select a PCP within their selected Health Network.

D. A OneCare Connect Member may select a specialist Provider as a PCP, within their selected Health Network, so long as the specialist Provider is willing to perform the role of the PCP and the specialist Provider is set up in OneCare Connect systems as a PCP and is open and available to Members.

E. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

F. If a Member fails to select a Health Network and a PCP prior to the Member's enrollment effective date, CalOptima shall assign such Member to a Health Network and a PCP in accordance with the terms and conditions of this Policy.

G. CalOptima may assign a Member to a Health Network if CalOptima and Centers for Medicare & Medicaid (CMS) eligibility information indicate a Member is eligible, even if the eligibility information received from the Department of Health Care Services (DHCS) does not indicate the

Member is eligible. Any eligibility discrepancies requiring regulatory action shall be submitted to CMS and/or DHCS for resolution, as appropriate.

H. CalOptima shall notify a Member, in writing, of the Member's Health Network and PCP assignment, with instructions on how the Member may change their Health Network and/or PCP.

I. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima, in accordance with the terms and conditions of this policy and CalOptima Policy CMC.4011: Notice of Change in Location and Availability of Covered Services.

J. If a Member transitions to a Long-Term Care (LTC) facility or is identified as residing in an LTC facility after enrollment, the Member may be assigned to the CalOptima Community Network (CCN) in accordance this policy.

K. CalOptima shall notify affected Members of a PCP or Health Network contract termination, in accordance with the terms and conditions of this policy.

III. PROCEDURE

A. For voluntary enrollments, if an individual completes an enrollment application during a face-to-face or telephonic interview with a qualified OneCare Connect enrollment representative, the representative shall assist the prospective Member in selecting a Health Network and a PCP at the time of the interview and completion of the application.

B. If a Member submits the OneCare Connect enrollment application by mail or facsimile, CalOptima enrollment staff shall use ensure the selection of a Health Network and/or PCP as follows:

1. If the Member selected a PCP but failed to select a Health Network, CalOptima shall assign the Member to a Health Network as follows:

   a. If the Member's selected PCP contracts with only one (1) Health Network, CalOptima shall assign the Member to that Health Network.

   b. If the Member's selected PCP contracts with more than one (1) Health Network, CalOptima shall contact the Member to obtain the Member's choice of Health Network.

   c. If CalOptima's attempt to contact the Member is unsuccessful, CalOptima shall assign the Member to a Health Network that contracts with the selected PCP, taking into consideration the geographic concentration of available Providers in the Health Network(s) in relation to the location of the Member's residence.

2. If the Member selected a Health Network, but failed to select a PCP, CalOptima shall assign the Member to a PCP as follows:

   1. CalOptima shall contact the Member to obtain the Member's PCP selection.

   2. If CalOptima's attempt to contact the Member is unsuccessful, CalOptima shall assign the Member to a PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

3. If the Member selected a PCP who is not available to new Members, CalOptima shall assign the Member to another PCP as follows:

    a. CalOptima shall contact the Member to inform the Member that the selected PCP is not available to new Members, and obtain the Member's new PCP selection.

    b. If CalOptima's attempt to contact the Member is unsuccessful, CalOptima shall assign the Member to another PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

4. If the Member fails to select both a Health Network and a PCP, CalOptima shall assign the Member to a Health Network and PCP as follows:

    a. CalOptima shall contact the Member to obtain the Member's choice of Health Network and PCP.

    b. If CalOptima's attempt to contact the Member is unsuccessful , CalOptima shall assign the Member to a Health Network and PCP, taking into consideration the geographic location of the Member's residence and the Member's preferred language, if available.

C. A Member may request to change their Health Network and/or PCP every month. A Member, their conservator, or the Member's Legal Representative shall contact the OneCare Connect Customer Service Department to request a Health Network and/or PCP change.

1. If the request to change the Health Network and/or PCP is received by CalOptima by close of business on the last business day of the month, the effective date with the new Health Network and/or PCP shall be the first (1st) calendar day of the immediately following calendar month.

2. If the request to change Health Network and/or PCP is received by OneCare Connect after the close of business on the last business day of the month, the effective date with the new Health Network and/or PCP shall be the first (1st) calendar day of the immediately following calendar month.

3. A Member may only select a PCP within their selected Health Network.

D. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima not later than sixty (60) calendar days prior to the PCP's contract termination date.

1. The Health Network(s) notice to CalOptima shall indicate an affected Member's new PCP assignment, the new PCP's name, and the new PCP's state license number, tax ID number, and NPI number (National Provider Identifier).

2. In the case of unforeseen circumstances (i.e., if the Health Network received less than sixty (60) calendar days notice from a PCP), the Health Network shall notify CalOptima of a PCP termination immediately upon receipt of such notice.

3. CalOptima shall make a good faith effort to notify an affected Member via telephone of a PCP termination no later than fifteen (15) calendar days after CalOptima receives notification from the Health Network or Provider. CalOptima's telephonic outreach to an affected Member shall include:

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a. A minimum of three (3) telephonic attempts to reach the Member

b. Provide the name and contact information of the Member's newly assigned PCP; and

c. Assist the Members in selecting a different PCP if they are not satisfied with their new PCP assignment.

E. Upon termination of a Health Network, CalOptima shall notify affected Members of a Health Network termination thirty (30) calendar days prior to the Health Network(s) contract termination date, or in the case of unforeseen circumstances, as soon as CalOptima receives notification from the Health Network.

1. CalOptima shall request the Members to select another Health Network.

2. If CalOptima is unable to contact a Member, or if the Member does not make a new Health Network selection prior to the end date of the terminating Health Network(s) contract, CalOptima shall assign the Member to an active Health Network contracted with the Member's current PCP.

3. If the Member's current PCP is not contracted with any other CalOptima Health Network, CalOptima shall assign the Member to a PCP and Health Network, taking into consideration the location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

F. Notwithstanding the above, if a Member:

1. Is known to reside in an LTC facility at enrollment, PCP and Health Network assignment shall be to:

a. The LTC facility; and

b. The provider rendering services to the Member at the LTC facility.

2. Transitions to an LTC after enrollment in OneCare Connect or is identified later as residing in an LTC:

a. If the current PCP does not participate with CalOptima Community Network, the Member will remain assigned to that PCP and Health Network.

b. If the current PCP participates with CalOptima Community Network, the Member will be assigned to CalOptima Community Network and the same PCP.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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
B. CalOptima Policy CMC.4003: Member Enrollment (Voluntary)
C. CalOptima Policy CMC.4011: Notice of Change in Location and Availability of Covered Services

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D. Title 42, Code of Federal Regulations (CFR.), §422.111(e)
E. Welfare and Institutions Code §14087.325(b)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2013	Regular Meeting of the CalOptima Board of Directors
05/07/2015	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2015	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	12/01/2015	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	08/01/2016	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	08/01/2017	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	07/01/2018	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	09/01/2019	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare Connect
Revised	TBD	CMC.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	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.
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.
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.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), 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.
Legal Representative	For the purposes of this policy, an individual who is the Legal Representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity. (Form CMS-1696 may not be used to appoint an Authorized Representative for the purposes of enrollment and disenrollment. This form is solely for use in the Claims Adjudication or Claim Appeals process, and does not provide broad legal authority to make another individual's healthcare decisions.)
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Member	A beneficiary enrolled in the CalOptima OneCare Connect program.
Primary Care Provider (PCP)	A physician who focuses their practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under Medicare.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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Policy:	MA.4010
Title:	**Health Network and Primary Care Provider Selection, Assignment, and Notification**
Department:	Customer Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima's process for Member selection of, or assignment to, a Health Network and Primary Care Provider (PCP) and the process to notify a Member of a PCP contract termination.

II. POLICY

A. CalOptima is committed to a Member's right to select a Health Network and a Primary Care Physician (PCP).

B. CalOptima shall ensure that a Member is enrolled in a Health Network, and assigned to a PCP, no later than the Member's effective date of OneCare coverage.

C. CalOptima shall request an individual to select a Health Network and a PCP at the time of enrollment with OneCare.

D. A Member may only select a PCP within his or her selected Health Network.

E. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

~~E.~~F. If a Member fails to select a Health Network and/or a PCP at the time of enrollment, CalOptima shall assign such Member to a Health Network and/or a PCP, in accordance with this Policy.

~~F.~~G. CalOptima shall notify a Member, in writing or by telephonic outreach, of the Member's Health Network and/or PCP assignment, with instructions on how the Member may change his or her Health Network and PCP.

~~G.~~H. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima, in accordance with the terms and conditions of this policy and CalOptima Policy

Back to Agenda Back to Item

EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory.

~~H.~~I. CalOptima shall notify affected Members of a PCP and/or Health Network contract termination, in accordance with this Policy.

III. PROCEDURE

A. If a Member completes the OneCare Enrollment Form during a face-to-face or telephonic interview, CalOptima staff shall assist the Member in selecting a Health Network and PCP.

B. If a Member submits the OneCare Enrollment Form to CalOptima by mail or facsimile, or makes the Election through another method approved by the Centers for Medicare & Medicaid Services (CMS), CalOptima staff shall ensure the Member's selection of a Health Network and PCP as follows:

1. If the Member selected a PCP, but failed to select a Health Network, CalOptima shall assign the Member to a Health Network as follows:

   a. If the Member's selected PCP contracts with only one (1) Health Network, CalOptima shall assign the Member to that Health Network.

   b. If the Member's selected PCP contracts with more than one (1) Health Network, CalOptima staff shall contact the Member to obtain the Member's choice of Health Network.

   c. If CalOptima staff is unable to contact the Member within the designated time frame, CalOptima staff shall contact the Member's PCP to determine a Health Network for the Member.

   d. If the PCP is unable to provide the Health Network selection within the same day of CalOptima's request, CalOptima shall assign the Member to a Health Network.

2. If the Member selected a Health Network, but failed to select a PCP, CalOptima shall assign the Member to a PCP as follows:

   a. CalOptima staff shall contact the Member to obtain the Member's PCP selection.

   b. If CalOptima staff is unable to contact the Member within the designated time frame, CalOptima shall assign the Member to a PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

3. If the Member selected a PCP, who is not available to new Members, CalOptima shall assign the Member to another PCP as follows:

   a. CalOptima staff shall contact the Member to inform the Member that the selected PCP is not available to new Members, and obtain the Member's new PCP selection.

   b. If CalOptima staff is unable to contact the Member within the designated time frame, CalOptima shall assign the Member to another PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

4. If the Member fails to select both a Health Network and a PCP, CalOptima shall assign the Member to a Health Network and PCP as follows:

    a. CalOptima staff shall contact the Member to obtain the Member's choice of Health Network and PCP.

    b. If CalOptima staff is unable to contact the Member within a designated timeframe, CalOptima shall assign the Member to a PCP and Health Network, taking into consideration the geographic location of the Member's residence and the Member's preferred language, if available.

C. A Member or Authorized Representative may request to change his or her Health Network or PCP at any time. A Member or Authorized Representative shall contact the CalOptima OneCare Customer Service Department to request a Health Network or PCP change.

1. If the Member requests to change his or her Health Network or PCP by close of business on the last business day of the month, the effective date with the new Health Network or PCP shall be the first (1st) calendar day of the immediate following month.

2. If the Member requests to change Health Network or PCP after the close of business on last business day of the month, the effective date with the new Health Network or PCP shall be the first (1st) calendar day of the month after the immediate following month.

3. A Member may only select a PCP within his or her selected Health Network.

D. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima no later than sixty (60) calendar days prior to the PCP's contract termination date.

1. The Health Network notice to CalOptima shall indicate an affected Member's new PCP assignment, the new PCP's name, and the new PCP's Medicare identification number.

2. In the case of unforeseen circumstances (i.e., if the Health Network received less than sixty (60) calendar ~~days~~days' notice from a PCP), the Health Network shall notify CalOptima of a PCP termination immediately upon receipt of such notice.

3. CalOptima shall make a good faith effort to notify an affected Member of a PCP termination thirty (30) calendar days prior to the PCP's contract termination date, or, in the case of unforeseen circumstances, as soon as CalOptima receives notification from the Health Network. CalOptima shall make a minimum of three (3) telephonic outreach attempts to inform the Member:

    a. The name and contact information of the Member's newly assigned PCP; and

    b. How the Member may select a different PCP if he or she is not satisfied with his or her new PCP assignment.

4. If the Member is not reached on the 3rd telephonic attempt, CalOptima shall send an "Unable to Reach You Notice" to the Member.

E. Upon termination of a Health Network, CalOptima shall notify an affected Member of a Health Network termination thirty (30) calendar days prior to the Health Network's contract termination date.

1. CalOptima's notice shall request the Member to contact CalOptima to select another Health Network.

2. If the Member does not contact CalOptima within the designated timeframe, CalOptima shall assign the Member to a Health Network contracted with the Member's selected PCP.

    a. If the Member's ~~selected~~currently assigned PCP contracts with more than one (1) Health Network, CalOptima staff shall contact the Member's ~~selected~~currently assigned PCP to determine a Health Network for the Member.

    b. If the Member's ~~selected~~currently assigned PCP is unable to provide the Health Network selection within the same day of CalOptima's request, or the Member's ~~selected~~currently assigned PCP is not contracted with any other Health Network, CalOptima shall assign the Member to a new Health Network and PCP.

    c. CalOptima shall assign the Member to a new PCP, taking into consideration the geographic location of the Member's residence and the Member's preferred language, if available.

IV. ATTACHMENT(S)

A. Notice of Physician Medical Group Termination
B. Unable to Reach You Notice

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy MA.4003: Member Enrollment
C. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.4010	Physician Group and PCP Selection, Assignment, and Notification	OneCare
Revised	07/01/2007	MA.4010	Physician Group and PCP Selection, Assignment, and Notification	OneCare
Revised	08/01/2012	MA.4010	Physician Medical Group and PCP Selection, Assignment and Notification	OneCare
Revised	02/01/2014	MA.4010	Physician Medical Group and PCP Selection, Assignment and Notification	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2016	MA.4010	Physician Medical Group and PCP Selection, Assignment and Notification	OneCare
Revised	05/01/2017	MA.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare
Revised	10/01/2019	MA.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare
Revised	TBD	MA.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare

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IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative 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 and as further described in CalOptima Policy HH.3009.
Election	Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election Period determines the effective date of MA coverage as well as the types of enrollment requests allowed.
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	For the purposes of this policy, an enrollee-beneficiary of the CalOptima OneCare program.
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG)~~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.
Primary Care Physician (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under OneCare.

Policy:	MA.4010
Title:	**Health Network and Primary Care Provider Selection, Assignment, and Notification**
Department:	Customer Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima's process for Member selection of, or assignment to, a Health Network and Primary Care Provider (PCP) and the process to notify a Member of a PCP contract termination.

II. POLICY

A. CalOptima is committed to a Member's right to select a Health Network and a Primary Care Physician (PCP).

B. CalOptima shall ensure that a Member is enrolled in a Health Network, and assigned to a PCP, no later than the Member's effective date of OneCare coverage.

C. CalOptima shall request an individual to select a Health Network and a PCP at the time of enrollment with OneCare.

D. A Member may only select a PCP within his or her selected Health Network.

E. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

F. If a Member fails to select a Health Network and/or a PCP at the time of enrollment, CalOptima shall assign such Member to a Health Network and/or a PCP, in accordance with this Policy.

G. CalOptima shall notify a Member, in writing or by telephonic outreach, of the Member's Health Network and/or PCP assignment, with instructions on how the Member may change his or her Health Network and PCP.

H. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima, in accordance with the terms and conditions of this policy and CalOptima Policy

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EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory.

I. CalOptima shall notify affected Members of a PCP and/or Health Network contract termination, in accordance with this Policy.

III. PROCEDURE

A. If a Member completes the OneCare Enrollment Form during a face-to-face or telephonic interview, CalOptima staff shall assist the Member in selecting a Health Network and PCP.

B. If a Member submits the OneCare Enrollment Form to CalOptima by mail or facsimile, or makes the Election through another method approved by the Centers for Medicare & Medicaid Services (CMS), CalOptima staff shall ensure the Member's selection of a Health Network and PCP as follows:

1. If the Member selected a PCP, but failed to select a Health Network, CalOptima shall assign the Member to a Health Network as follows:

   a. If the Member's selected PCP contracts with only one (1) Health Network, CalOptima shall assign the Member to that Health Network.

   b. If the Member's selected PCP contracts with more than one (1) Health Network, CalOptima staff shall contact the Member to obtain the Member's choice of Health Network.

   c. If CalOptima staff is unable to contact the Member within the designated time frame, CalOptima staff shall contact the Member's PCP to determine a Health Network for the Member.

   d. If the PCP is unable to provide the Health Network selection within the same day of CalOptima's request, CalOptima shall assign the Member to a Health Network.

2. If the Member selected a Health Network, but failed to select a PCP, CalOptima shall assign the Member to a PCP as follows:

   a. CalOptima staff shall contact the Member to obtain the Member's PCP selection.

   b. If CalOptima staff is unable to contact the Member within the designated time frame, CalOptima shall assign the Member to a PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

3. If the Member selected a PCP, who is not available to new Members, CalOptima shall assign the Member to another PCP as follows:

   a. CalOptima staff shall contact the Member to inform the Member that the selected PCP is not available to new Members, and obtain the Member's new PCP selection.

   b. If CalOptima staff is unable to contact the Member within the designated time frame, CalOptima shall assign the Member to another PCP contracted with the Member's Health Network, taking into consideration the geographic location of the PCP's office in relation to the Member's residence and the Member's preferred language, if available.

4. If the Member fails to select both a Health Network and a PCP, CalOptima shall assign the Member to a Health Network and PCP as follows:

    a. CalOptima staff shall contact the Member to obtain the Member's choice of Health Network and PCP.

    b. If CalOptima staff is unable to contact the Member within a designated timeframe, CalOptima shall assign the Member to a PCP and Health Network, taking into consideration the geographic location of the Member's residence and the Member's preferred language, if available.

C. A Member or Authorized Representative may request to change his or her Health Network or PCP at any time. A Member or Authorized Representative shall contact the CalOptima OneCare Customer Service Department to request a Health Network or PCP change.

1. If the Member requests to change his or her Health Network or PCP by close of business on the last business day of the month, the effective date with the new Health Network or PCP shall be the first (1st) calendar day of the immediate following month.

2. If the Member requests to change Health Network or PCP after the close of business on last business day of the month, the effective date with the new Health Network or PCP shall be the first (1st) calendar day of the month after the immediate following month.

3. A Member may only select a PCP within his or her selected Health Network.

D. Upon termination of a PCP's contract with a Health Network, the Health Network shall notify CalOptima no later than sixty (60) calendar days prior to the PCP's contract termination date.

1. The Health Network notice to CalOptima shall indicate an affected Member's new PCP assignment, the new PCP's name, and the new PCP's Medicare identification number.

2. In the case of unforeseen circumstances (i.e., if the Health Network received less than sixty (60) calendar days' notice from a PCP), the Health Network shall notify CalOptima of a PCP termination immediately upon receipt of such notice.

3. CalOptima shall make a good faith effort to notify an affected Member of a PCP termination thirty (30) calendar days prior to the PCP's contract termination date, or, in the case of unforeseen circumstances, as soon as CalOptima receives notification from the Health Network. CalOptima shall make a minimum of three (3) telephonic outreach attempts to inform the Member:

    a. The name and contact information of the Member's newly assigned PCP; and

    b. How the Member may select a different PCP if he or she is not satisfied with his or her new PCP assignment.

4. If the Member is not reached on the 3rd telephonic attempt, CalOptima shall send an "Unable to Reach You Notice" to the Member.

E. Upon termination of a Health Network, CalOptima shall notify an affected Member of a Health Network termination thirty (30) calendar days prior to the Health Network's contract termination date.

1. CalOptima's notice shall request the Member to contact CalOptima to select another Health Network.

2. If the Member does not contact CalOptima within the designated timeframe, CalOptima shall assign the Member to a Health Network contracted with the Member's selected PCP.

    a. If the Member's currently assigned PCP contracts with more than one (1) Health Network, CalOptima staff shall contact the Member's currently assigned PCP to determine a Health Network for the Member.

    b. If the Member's currently assigned PCP is unable to provide the Health Network selection within the same day of CalOptima's request, or the Member's currently assigned PCP is not contracted with any other Health Network, CalOptima shall assign the Member to a new Health Network and PCP.

    c. CalOptima shall assign the Member to a new PCP, taking into consideration the geographic location of the Member's residence and the Member's preferred language, if available.

IV. ATTACHMENT(S)

A. Notice of Physician Medical Group Termination
B. Unable to Reach You Notice

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
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VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.4010	Physician Group and PCP Selection, Assignment, and Notification	OneCare
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Revised	08/01/2012	MA.4010	Physician Medical Group and PCP Selection, Assignment and Notification	OneCare
Revised	02/01/2014	MA.4010	Physician Medical Group and PCP Selection, Assignment and Notification	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2016	MA.4010	Physician Medical Group and PCP Selection, Assignment and Notification	OneCare
Revised	05/01/2017	MA.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare
Revised	10/01/2019	MA.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare
Revised	TBD	MA.4010	Health Network and Primary Care Provider Selection, Assignment, and Notification	OneCare

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IX. GLOSSARY

Term	Definition
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Election	Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election Period determines the effective date of MA coverage as well as the types of enrollment requests allowed.
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	For the purposes of this policy, an enrollee-beneficiary of the CalOptima OneCare program.
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.
Primary Care Physician (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under OneCare.

[DATE]

[Member Name]
[Member Address]
[City State ZIP]

Dear [Member Name]:

Your OneCare Primary Care Provider (PCP) is associated with [PMG Name]. As of [Date of Termination], [PMG Name] will no longer be a OneCare Physician Medical Group (PMG). This means you will need to choose a new PMG and you may also need to choose a new PCP. This change will not affect your benefits or coverage as a OneCare member.

You can continue to get health care services from your current PCP and [PMG Name] through [Effective Date of Termination]. It is important, however, that you make a choice before [Effective Date of Termination].

Please refer to your Provider Directory for a list of available PCPs and PMGs, or visit our website at www.caloptima.org/onecare and view the Provider Directory online. We will be contacting you very soon by phone to help you choose a new PMG and a new PCP if necessary. Or, you may call OneCare Customer Service and ask us to help you with these changes. If you have already been contacted by OneCare and you have given us your choices, you can disregard this notice.

If we cannot reach you and you do not contact us directly, we will choose a PCP and PMG for you, so that you continue to have access to health care.

What if I am currently receiving care from my PCP/Specialist?
You may be able to keep seeing your PCP/Specialist if you are receiving care. Call OneCare's Customer Service Department toll-free at 1-877-412-2734 for help. TTY/TDD users can call 1-800-735-2929.

Please note, your hospital and specialty physicians may change as a result of your PMG change. It is important that you call OneCare Customer Service if:

- You are currently undergoing medical care or have a scheduled surgery. If so we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.

- You have a prior authorization in process.

H5433_MM1013 CMS Approved

- You are in need of help with any health care services you're currently receiving.

If you have questions, please call our Customer Service Department toll-free 7 days a week, 24 hours a day, at **1-877-412-2734** or visit our office Monday through Friday, from 8 a.m. to 5 p.m. at 505 City Parkway West, Orange, CA 92868. TTY/TDD users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org/onecare**.

Sincerely,

OneCare Customer Service

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. Other Pharmacy/Physicians/Providers are available in our network. This information is available for free in other languages. Please call our Customer Service number at 1-877-412-2734 for additional information. TTY users should call 1-800-735-2929, 24 hours a day, 7 days a week. To get an interpreter, Customer Service has free language interpreter services available for non-English speakers. This information is available in a different format (ex. large print, audio tapes). Please call Customer Service if you need plan information in another format.

Esta información está disponible gratis en otros idiomas. Para más información, por favor llame al Departamento de Servicios para Miembros al 1-877-412-2734, las 24 horas al día, los 7 días de la semana. (Usuarios de la línea TTY pueden llamar al 1-800-735-2929). El Departamento de Servicios para Miembros cuenta con servicios de intérprete gratuitos para aquellos miembros que no hablan inglés. Esta información está disponible en otros formatos (por ejemplo, impresa grande y cintas de audio). Si necesita información del plan en otro formato, por favor llame al Departamento de Servicios para Miembros al número de teléfono que aparece arriba.

Thông tin này cũng có sẵn miễn phí bằng những ngôn ngữ khác. Xin vui lòng liên lạc Văn Phòng Dịch Vụ của chúng tôi qua số điện thoại 1-877-412-2734 để biết thêm chi tiết. (Thành viên sử dụng máy TTY có thể liên lạc qua số 1-800-735-2929). Quý vị có thể liên lạc 24 giờ một ngày, 7 ngày một tuần. Văn Phòng Dịch Vụ có dịch vụ thông dịch miễn phí cho các thành viên không nói tiếng Anh. Thông tin này có sẵn bằng những hình thức khác (ví dụ như khổ chữ in lớn, qua băng thâu thanh). Xin vui lòng liên lạc Văn Phòng Dịch Vụ ở số điện thoại ghi phía trên nếu quý vị cần thông tin về chương trình bằng những hình thức khác.

OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

[Date]

[Member Name]
[Address]
[City, State Zip]

Dear [Member Name]:

We recently tried to call you, but have not been able to reach you. We would like to contact you by telephone if that is possible.

Please call OneCare Customer Service at your earliest convenience at **1-877-412-2734**. Let us know if your phone number has changed.

You can call Customer Service toll-free 7 days a week, 24 hours a day, at **1-877-412-2734.** TTY/TDD users can call toll-free at **1-800-735-2929**.

Sincerely,

Customer Service Department

OneCare (HMO SNP) is a Coordinated Care plan with a Medicare Advantage contract and a contract with the California Medicaid program.

Policy:	CMC.4003
Title:	**Member Enrollment (Voluntary)**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Schrader 03/25/2020*
Effective Date:	05/01/2015
Revised Date:	03/01/2020

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy describes procedures for enrolling an individual in OneCare Connect through voluntary enrollment.

II. POLICY

A. Subject to the provisions of this Policy, an individual is eligible to elect the OneCare Connect plan in accordance with the three-way contract between CalOptima, the Centers for Medicare & Medicaid Services (CMS), and the Department of Health Care Services (DHCS) when they meet all of the following requirements:

1. The individual is entitled to, or enrolled in, Medicare Part A and Part B and eligible to enroll in a Part D plan as of the effective date of coverage under OneCare Connect.

2. The individual permanently resides in Orange County, the OneCare Connect Service Area, and is a U.S. citizen or lawfully present in the United States;

3. The individual, their Legal Representative, or DHCS or CMS, on behalf of the individual, completes an enrollment request and includes all the information required to process the enrollment, or meets alternative conditions for enrollment specified by CMS;

4. The individual is eligible for full Medi-Cal (Medicaid) through CalOptima's contract with the DHCS, including:

   a. Individuals enrolled in the Multipurpose Senior Services Program (MSSP);

   b. Individuals without Share of Cost; and

   c. Individuals with Share of Cost enrolled in the following:

      i. Nursing facility residents;

      ii. MSSP enrollees; or

      iii. In-Home Supportive Services (IHSS) recipients.

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5. The individual is not in the following 1915(c) waivers:

    a. Nursing Facility/Acute Hospital Waiver;

    b. AIDS Medi-Cal Waiver Program (MCWP);

    c. Assisted Living Waiver (ALW); or

    d. In-Home Operations Waiver.

6. The individual is not Developmentally Disabled, receiving services through a DDS 1915(c) waiver, regional center, or state developmental center;

7. The individual is not an Intermediate Care Facility-Developmentally Disabled (ICF-DD) Resident;

8. The individual is age twenty-one (21), or older;

9. The individual is not covered under an employee benefit plan through an employer, union, or spouse's group health benefits program, or has any Other Health Coverage;

10. The individual is fully informed of, and agrees to abide by, the rules of the OneCare Connect program that were provided during the enrollment process; and

11. The individual is not currently "at risk" or "potentially at risk" under the Comprehensive Addiction and Recovery Act (CARA) and flagged in the Medicare Advantage Prescription Drug (MARx) System User Interface (UI) as such.

B. Following enrollment, if the individual has a Medi-Cal Share of Cost, they must meet it each month of continuous enrollment by being in a Medi-Cal funded nursing facility, Long Term Care (LTC) facility, Multi Senior Services Program (MSSP), or receiving In-Home Supportive Services (IHSS).

C. CalOptima shall not impose any additional eligibility requirements as a condition of enrollment other than those described in the Memorandum of Understanding (MOU) between CMS and the State of California, the three-way contract between CalOptima, DHCS, and CMS, or established by the State and CMS in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

D. CalOptima shall not deny enrollment in OneCare Connect to any individual who has elected the hospice benefit. Until CalOptima acknowledges receipt of a completed enrollment form and gives a coverage effective date to the individual, CalOptima shall not ask any questions related to the existence of a terminal illness or Election of the hospice benefit.

E. CalOptima may ask health related questions during an individual's completion of the voluntary enrollment request form for the purpose of successful care management and transition of care activities, such as whether the individual has end-stage renal disease (ESRD). These questions shall be asked subsequent to the requirement enrollment request elements. The individual is not required to answer health related questions in order for the enrollment request to be processed, and responses to such questions shall not have an effect on an individual's eligibility to enroll in OneCare Connect.

F. CalOptima shall ask whether the individual is currently admitted to a certified Medicare or Medicaid nursing facility or is receiving IHSS or MSSP, for the purpose of determining eligibility for an individual who has a Medi-Cal Share of Cost.

G. The Election Period in which a Member makes an Election shall determine the effective date, in accordance with CalOptima Policy CMC.4005: Election Periods and Effective Dates.

H. CalOptima shall retain all enrollment forms for the current contract period and ten (10) prior periods.

III. PROCEDURE

A. Enrollment Process (Voluntary):

1. Voluntary enrollment in OneCare Connect is predicated on a beneficiary completing an enrollment request. The enrollment request may be made by the eligible individual or the individual's Legal Representative. CalOptima must deny enrollment to any individual who does not properly complete the voluntary enrollment request, within time frames established in MMP enrollment guidance.

2. An individual is eligible to enroll in OneCare Connect if they are fully informed of, and agree to abide by, the rules of OneCare Connect that were provided during the enrollment process. Fully informed means that the individual must be provided the applicable rules of the MMP as described in the MMP Enrollment/Disenrollment Guidance.

3. CalOptima shall deny enrollment to any individual who does not properly complete the voluntary enrollment request within required time frames in accordance with MMP Enrollment/Disenrollment Guidance.

4. If CalOptima mails Marketing Materials together with an enrollment form to an individual, such mailing shall be considered an Enrollment Kit. An Enrollment Kit shall include:

    a. Cover Letter which includes OneCare Connect's toll-free Customer Service telephone number, TTY number, Customer Service hours of operation, physical address, and notice that the individual may contact Medicare for further information on Medicare benefits and services;

    b. Summary of Benefits;

    c. Enrollment form instructions;

    d. Combined Pharmacy and Provider directory insert; and

    e. Multi-language inserts.

5. The enrollment form shall include the following statements that the individual:

    a. Understands the requirement to keep Medicare Part A and Part B;

    b. Agrees to abide by the OneCare Connect membership rules, as outlined in materials provided to the individual, including the Provider access requirement;

c. Consents to the Disclosure and exchange of necessary information to provide Covered Services;

d. Understands that enrollment in OneCare Connect automatically disenrolls the individual from any other Medicare, or prescription drug plan in which they are enrolled;

e. Knows that the effective date is the date they shall begin receiving care through OneCare Connect;

f. Knows they have the right to Appeal service and payment denials made by CalOptima;

g. Understands that to qualify for OneCare Connect, the individual must be entitled to receive services under Medi-Cal;

h. Understands that prescription drugs are covered, but not always the same drugs the individual is already taking, and that the individual shall have access to at least one (1) thirty (30)-day supply of their current Part D drugs for at least ninety (90) calendar days, until they can switch to a different drug;

i. Understands that they shall have access to their current doctors for up to twelve (12) months for Medicare and Medi-Cal services from the effective date of enrollment, pursuant to CalOptima Policy CMC.6021a: Continuity of Care for New Members;

j. Knows that OneCare Connect may share their information, including prescription drug information, with Medicare and Medi-Cal, and that it may be released for research and other purposes as allowed by Federal statutes and regulations.

6. An individual shall submit an original enrollment form, except if they submit the enrollment form by facsimile. Enrollments shall not be accepted by phone.

B. Verification of Information:

1. If an individual completes an enrollment form during a face-to-face or telephonic interview, OneCare Connect sales staff shall use the individual's Medicare card to verify the spelling of the individual's name and to confirm the correct recording of gender, Medicare Beneficiary Identifier (MBI) number, and dates of entitlement to receive services under Medicare Part A and Part B, when possible.

2. If an individual submits an enrollment form to CalOptima by mail or facsimile (fax) or makes the Election through another CMS-approved method, CalOptima shall verify the individual's name, gender, MBI number, and dates of entitlement to receive services under Medicare Part A and Part B by telephone or other means, or request that the individual includes a copy of their Medicare card when mailing/faxing the enrollment form to CalOptima.

3. CalOptima shall ensure that all of the following data elements are included and accurate:

a. Permanent Residence Information: The individual shall have a permanent residence address to determine that they reside within the OneCare Connect Service Area. If an individual indicates a Post Office Box as their place of residence on the enrollment form, CalOptima may consider the enrollment form incomplete and shall contact the individual to determine the individual's place of permanent residence. If the individual claims permanent residency in two (2) or more states, or if there is a dispute over where the individual permanently resides, CalOptima shall consider California state guidance in determining whether the

enrollee is considered a resident of the state. In the case of a homeless individual, CalOptima shall consider a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) as the place of permanent residence.

b. Medicare Entitlement Information: CalOptima may accept the following as evidence of an individual's entitlement to Medicare Part A and Part B:

   i. Medicare card; or

   ii. Verification of Medicare Part A and Part B through one of CMS' systems, including CMS data available through CMS subcontractors.

c. Medi-Cal Entitlement Information: CalOptima may accept the following as evidence of an individual's entitlement to Medi-Cal benefits:

   i. Verification through the State of California beneficiary eligibility verification system; or

   ii. CalOptima's Medi-Cal membership system.

d. Comprehensive Addition and Recovery Act (CARA): CalOptima shall confirm the individual is not "at risk" or "potentially at risk".

   i. CalOptima shall follow the lock-in requirement for a beneficiary in this category up to a period of twenty-four (24) months unless the CMS System indicates an earlier end to the period.

e. Statement of Understanding: An individual shall understand and agree to abide by the rules of OneCare Connect in order to enroll.

   i. CalOptima shall consider the beneficiary signature on the enrollment form (or completion of the enrollment process) to signify that the individual has read and understands the statements on the form.

   ii. If an enrollment request is received in the mail or by fax, CalOptima shall contact the individual to review the Election requirements, complete the enrollment form, and verify the individual's signature. If CalOptima is unable to contact the individual to ensure understanding, CalOptima shall consider the enrollment form incomplete.

f. Enrollee Signature and Date: An individual shall sign the enrollment form. If the individual is unable to sign the form, an Authorized Representative shall sign the enrollment form. If an Authorized Representative signs the form for the individual, the Authorized Representative must attest to having the authority to do so under state law and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by state law that empowers the Authorized Representative to effect an enrollment request on behalf of the applicant is available and can be presented upon request. The individual, or Authorized Representative, shall indicate the date they signed the enrollment form. If they inadvertently fail to include the date on the enrollment form, CalOptima shall stamp the date of receipt on the enrollment form, and such date shall serve as the signature date of the form. If CalOptima has reason to believe that an individual making an Election on behalf of a Member may not be authorized under State law to do so, CalOptima shall contact CMS, in accordance with the Medicare-Medicaid Plan Enrollment

and Disenrollment Guidance.

i. Other Signatures: If a OneCare Connect representative or any other person helps the individual complete an enrollment form, they shall also sign the enrollment form and indicate their relationship to the individual. However, the form does not require co-signature if such OneCare Connect representative, or person:

a) Pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to them;

b) Fills in the "office use only" block; or

c) Corrects information on the enrollment form after verifying information, in accordance with Section III.B.3.g of this Policy.

ii. Signature Dates: If CalOptima receives an enrollment form that was signed more than thirty (30) calendar days prior to CalOptima's receipt of the form, CalOptima shall contact the individual to reaffirm the individual's intent to enroll prior to processing the enrollment and to advise the individual of the upcoming effective date.

iii. If a paper enrollment form is submitted and the signature is not included, CalOptima shall verify the individual's intent to enroll with a phone call and document the contact, rather than return the paper enrollment form as incomplete. The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).

g. Determining the Application Date: CalOptima shall date stamp all enrollment forms upon initial receipt in the enrollment office. If the enrollment form is complete at the time it is date stamped, then the date stamp is equivalent to the "Application Date". If the enrollment form is not complete at the time it is date stamped, CalOptima shall date stamp the additional documentation required for the enrollment form to be complete upon receipt. OneCare Connect shall consider the date stamp on the last piece of additional documentation as the "Application Date."

h. Final Verification of Information: If CalOptima makes corrections to an individual's enrollment form, the individual making those corrections shall place their initials and the date next to the correction. OneCare Connect may use a separate "correction" sheet, signed and dated by the individual making the correction, in place of the initialing procedure.

i. Completed enrollment forms: Once the enrollment form is complete, CalOptima shall transmit the enrollment to CMS within the time frames set forth in Section III.F of this Policy.

4. If CalOptima receives an enrollment form that contains all elements described in Section III.B.3 of this Policy, including any elements defined by OneCare Connect and approved by CMS, CalOptima shall consider the enrollment form complete even if all other data elements on the enrollment form are not filled out.

C. If CalOptima receives an enrollment form that does not have all necessary elements required in order to consider the enrollment form complete, CalOptima shall consider the enrollment incomplete.

1. CalOptima shall contact the individual within ten (10) calendar days after receipt of the

enrollment form to request additional information to complete the enrollment form.

a. If CalOptima verbally contacts the individual, CalOptima shall document the contact and shall retain documentation of such contact in its records.

b. CalOptima shall explain to the individual that the additional information must be received by CalOptima no later than the end of the month in which the enrollment form was received or twenty-one (21) calendar days after the date the additional information/documentation was requested, whichever is later.

c. For incomplete enrollment requests received prior to the month of entitlement to Medicare Part A and enrollment in Part B, CalOptima shall explain to the individual that the additional information/documentation to make the request complete must be received by the end of the month immediately preceding the individual's Part A and Part B effective date, or within twenty-one (21) calendar days of the request for additional information, whichever is later.

d. If CalOptima does not receive the additional information within the allowable time frame, CalOptima shall deny the enrollment.

e. If the individual does not provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment form, CalOptima may obtain such evidence through available CMS systems within ten (10) calendar days after receipt of the enrollment form.

j. If the CMS systems indicate that the individual is entitled to Medicare Part A and enrolled in Part B, and CalOptima has all the other information it needs to complete the enrollment form, CalOptima shall consider the enrollment form complete.

ii. If the CMS systems do not provide evidence of entitlement, CalOptima shall promptly contact the individual to obtain such evidence in accordance to Sections III.C.1 and 2 of this Policy.

2. CalOptima shall document all efforts to obtain necessary information to complete the enrollment form.

3. If CalOptima receives all documentation within allowable time frame and the enrollment form is complete, CalOptima shall transmit the enrollment to CMS, in accordance with this Policy.

4. If CalOptima does not receive the documentation needed to make the enrollment form complete within the allowable time frame, CalOptima must deny the enrollment, in accordance with Section III.D of this Policy.

D. Denial of Enrollment:

1. CalOptima shall deny an individual enrollment in OneCare Connect based on:

a. Its determination of the ineligibility of the individual to elect OneCare Connect as set forth in this Policy; or

b. The individual's failure to provide information to complete the enrollment form in accordance with this Policy.

2. CalOptima shall send written notice of denial to an individual, including an explanation of the reason for denial, within ten (10) calendar days after its denial determination, or expiration of the time frame to provide the required information/documentation.

E. Effective Date of Coverage: CalOptima shall determine an individual's effective date of coverage with OneCare Connect, in accordance with CalOptima Policy CMC.4005: Election Periods and Effective Dates.

1. If the individual completes an enrollment form in a face-to-face or telephonic interview, the OneCare Connect representative may advise the individual of the proposed effective date, but shall also stress to the individual that it is only a proposed effective date, and that the individual shall receive confirmation directly from CalOptima regarding the actual effective date. CalOptima shall notify the individual of the effective date of coverage prior to the effective date and shall indicate the actual effective date on the enrollment form, where applicable.

2. CalOptima shall assign the appropriate effective date based on the Election Period.

   a. Medicare-Medicaid enrollees who are entitled to Medicare Part A, Part B, and Part D and receive any type of assistance from the Title XIX (Medicaid) program have a continuous Medicare Special Enrollment Period (SEP) to request enrollment in, or disenrollment from a Medicare health or drug plan.

   b. The effective date of an Election made using this SEP is the first of the month following receipt of the enrollment or disenrollment request.

   c. During face-to-face or telephonic enrollments, the OneCare Connect representative shall ensure that an individual does not choose an effective date other than the one that is applicable.

3. If an individual completes an enrollment form with an unallowable effective date, or if the OneCare Connect representative allows the individual to choose an unallowable effective date, CalOptima shall notify the individual in a timely manner, and explain that CalOptima shall process the enrollment with a different effective date. CalOptima shall resolve the issue with the individual as to the correct effective date and document the notification. If the individual refuses to have the enrollment processed with the correct effective date, the individual may cancel the Election.

F. Transmission of Enrollment to CMS:

1. CalOptima shall submit information necessary for CMS to add an individual to its records as a member to CMS within seven (7) calendar days after receipt of a completed enrollment form. CMS counts the enrollment request receipt date as day zero.

2. CalOptima shall process enrollment forms in chronological order by date of receipt of completed enrollment forms.

G. Prior to an individual's effective date of coverage, or within ten (10) calendar days of receipt of CMS confirmation of acceptance of enrollment, CalOptima shall provide the individual with:

1. A copy of the completed enrollment form, if the individual does not already have a copy of the enrollment form and a paper application was used;

2. A letter acknowledging receipt of the completed enrollment request and confirming Medicare and Medicaid approval of enrollment, showing the effective date of coverage. This notice must be mailed no later than seven (7) calendar days after receipt of the Daily Transaction Reply Report (DTRR) from CMS confirming acceptance of the enrollment;

3. Evidence of health insurance coverage (Member Handbook) so that the individual may begin using OneCare Connect services as of the actual effective date;

4. A Summary of Benefits;

5. A combined Provider/Pharmacy directory insert; and

6. Comprehensive Integrated Formulary.

H. Regardless of an individual's Election in a face-to-face interview, by fax, by mail, or by other mechanisms defined by CMS, CalOptima shall explain:

1. The prospective Member's liability for charges and any amounts attributable to the Medicare deductible and coinsurance;

2. The prospective Member's authorization for the Disclosure and exchange of necessary information between CalOptima and CMS;

3. The potential Member financial liability if it is found that they are not entitled to Medicare Part A and Part B at the time coverage begins and have used OneCare Connect services after the effective date; and

4. The effective date of coverage and how to obtain services prior to the receipt of a OneCare Connect identification (ID) card.

I. Outbound Enrollment and Verification (OEV):

1. The OEV requirements in this section apply with respect to voluntary opt-in enrollments effectuated by plan employed agents.

2. Within fifteen (15) calendar days after receipt of the completed application from an individual, CalOptima OneCare Connect Customer Service shall contact the individual by mail to ensure they requested the enrollment and understands the rules of OneCare Connect.

3. CalOptima shall utilize an approved CMS verification letter.

J. Prior to enrollment, CalOptima shall obtain an acknowledgment by the individual that they understand the requirement for a Member to access services through designated Providers within OneCare Connect with the exception of Emergency Services and Urgent Care.

K. If CalOptima is unable to mail the materials described in Section III.G of this Policy to the individual prior to the effective date, CalOptima:

1. May verbally contact the individual within three (3) calendar days after the availability of the Daily Transaction Reply Report (DTRR) to provide the effective date, the information necessary to access benefits and to explain OneCare Connect rules; and

2. Shall mail such materials no later than seven (7) calendar days after receipt of the DTRR from CMS confirming acceptance of the enrollment.

L. Acceptance or Rejection of Enrollment:

1. Upon receipt of a DTRR report from CMS indicating whether the individual's enrollment has been accepted or rejected, CalOptima shall notify the individual in writing of CMS' acceptance or rejection within seven (7) calendar days after the availability of the DTRR.

2. If CalOptima rejects an enrollment and later receives additional information from the individual substantiating eligibility, CalOptima shall obtain a new enrollment request from the individual in order to enroll the individual and process the enrollment with a current, i.e., not retroactive, effective date.

3. During the voluntary enrollment process, CalOptima shall check State and CMS systems for employer or union coverage and, if no data are available, ask detailed questions to determine whether such coverage exists. Once an individual has been identified as having Other Health Coverage, or other exclusionary criteria, e.g., waiver programs, CalOptima shall cease the enrollment process and inform the individual that they are not eligible to enroll in the OneCare Connect plan.

4. Within ten (10) calendar days of receipt of DTRR report indicating Part D enrollment rejection due to an individual’s existing employer/union coverage, CalOptima shall send a notice to the individual that they are not eligible to enroll in OneCare Connect due to having Other Health Coverage.

M. Enrollments Not Legally Valid:

1. An enrollment is not legally valid if:

a. The enrollment form is not complete;

b. An enrollment request was signed by the individual, when a Legal Representative should have signed for the individual;

c. CalOptima determines at a later date that the individual did not meet eligibility requirements at the time of enrollment;

d. The individual enrolled in a supplemental insurance program immediately after enrolling in OneCare Connect;

e. The individual, or the individual’s Authorized Representative, did not intend to enroll the individual in OneCare Connect; or

f. The individual received non-emergency, or non-urgent, services out-of-plan immediately after the effective date of coverage under OneCare Connect.

2. If there is evidence that the individual did not intend to enroll in OneCare Connect, CalOptima shall submit a retroactive disenrollment request to CMS.

N. Retroactive Enrollment:

1. The request for a retroactive enrollment shall be made within the time frames provided in the

Standard Operating Procedure for the CMS Retroactive Processing Contractor (RPC).

2. When an individual has fulfilled all enrollment requirements, but CalOptima, or CMS, has not been able to process the enrollment in a timely manner, the following documentation must be submitted to CMS or the RPC:

    a. A copy of the signed and completed enrollment form, signed and received by CalOptima prior to the requested effective date of coverage; or

    b. A copy of the enrollment request record showing that the enrollment request was made and received by CalOptima prior to the requested effective date of coverage.

3. CMS shall only process requests for retroactive enrollments when CalOptima has notified the individual that they shall use OneCare Connect services during the period covered by the retroactive enrollment request.

4. CalOptima shall not make retroactive enrollments back to a date when OneCare Connect was closed for enrollment.

5. If CalOptima makes a retroactive request that is a result of a CalOptima error, CalOptima shall provide a clear and detailed explanation of the plan error including why the retroactive action is necessary to correct the error. The explanation shall include:

    a. Clear information regarding what CalOptima has communicated to the affected beneficiary throughout the period in question; and

    b. Any relevant information, or documentation, supporting the requested correction, for example:

        i. A copy of the enrollment request form (or clear evidence of the use of another enrollment mechanism); and

        ii. Evidence of notices sent to the individual related to, or caused by, the error.

O. Prior to the effective date of enrollment, within ten (10) calendar days after receipt of the DTRR from CMS confirming enrollment acceptance, CalOptima shall provide all Members with information including, but not limited to:

    1. Welcome letter;

    2. OneCare Connect identification (ID) card;

    3. Member Handbook;

    4. Member rights and responsibilities;

    5. Provider/Pharmacy Directory insert;

    6. Pharmacy information;

    7. Formulary;

    8. Vision services information;

9. New Member orientation information; and

10. OneCare Connect Customer Service contact information**.**

IV. ATTACHMENT(S)

A. OneCare Connect Enrollment Form
B. Notice for OneCare Connect Denial of Enrollment

V. REFERENCE(S)

A. California Medicare-Medicaid Plan Enrollment and Disenrollment Guidance
B. CalOptima Policy CMC.4005: Election Periods and Effective Dates
C. CalOptima Policy CMC.6021a: Continuity of Care for New Members
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicare Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. Final Contract Year (CY) 2020 Medicare Marketing Guidance for California Medicare-Medicaid Plans
F. Medicare Marketing Guidelines for Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drugs Plans, and 1876 Cost Plans (Issued July 20, 2017)
G. Medicare-Medicaid Plan (MMP) Enrollment and Disenrollment Guidance (Revised: August 2, 2018, eff 01/01/2019)
H. Memorandum of Understanding (MOU) Between CMS and the State of California
I. Title 42, Code of Federal Regulations (CFR) §§422.66(b) and 422.74

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2015	CMC.4003	Member Enrollment (Voluntary)	OneCare Connect
Revised	07/01/2016	CMC.4003	Member Enrollment (Voluntary)	OneCare Connect
Revised	07/01/2017	CMC.4003	Member Enrollment (Voluntary)	OneCare Connect
Revised	07/01/2018	CMC.4003	Member Enrollment (Voluntary)	OneCare Connect
Revised	01/01/2019	CMC.4003	Member Enrollment (Voluntary)	OneCare Connect
Revised	03/01/2020	CMC.4003	Member Enrollment (Voluntary)	OneCare Connect

IX. GLOSSARY

Term	Definition
AIDS Medi-Cal Waiver Program (MCWP)	A waiver program authorized by the Centers for Medicare and Medicaid Services (CMS) for Medi-Cal recipients under Title XIX of the Social Security Act.
Appeal	In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.
Application Date	For paper enrollment forms and other enrollment request mechanisms, the Application Date is the date the enrollment request is initially received by the organization as defined by the method of enrollment. Plans must use this date in the appropriate field when submitting enrollment transactions to Centers of Medicare & Medicaid Services (CMS). For requests submitted to sales agents, including brokers, the Application Date is the date the agent/broker receives (accepts) the enrollment request and not the date the organization receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the organization, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date.
Assisted Living Waiver	A Home and Community-Based Services (HCBS) waiver program that was created by legislation that directed the California Department of Health Care Services (DHCS) to develop and implement the project to test the efficacy of assisted living as a Medi-Cal benefit.
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	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.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
Developmental Disability	A disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.
Disclosure	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Election	Enrollment in or voluntary disenrollment from a Medicare Advantage Plan (MA) or a Medicare Medicaid Plan (MMP) or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan, a Medicare Medicaid Plan (MMP) or Original Medicare. The Election period determines the effective date of MA coverage.

Term	Definition
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
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.
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Intermediate Care Facility (ICF)	A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Legal Representative or Authorized Representative	An individual who is the Legal Representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity. (Form CMS-1696 may not be used to appoint an Authorized Representative for the purposes of enrollment and disenrollment. This form is solely for use in the Claims Adjudication or Claim Appeals process, and does not provide broad legal authority to make another individual's healthcare decisions.)
Long Term Care	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Marketing Materials	Marketing Materials: Materials defined in the Centers for Medicare & Medicaid Services (CMS) marketing guidelines set forth in the Medicare Managed Care Manual as any informative materials targeted to Medicare beneficiaries that: 1. Promotes or communicates or explains the Medicare Medicaid plan (MMP); 2. Informs Medicare beneficiaries that they may enroll, or remain enrolled in, the MMP; 3. Explains the benefits of enrollment in the MMP or rules that apply to enrollees; and 4. Explains how Medicare services are covered under the MMP including conditions that apply to such coverage. Marketing Materials include notification forms and letters used to enroll, disenroll, and communicate with a Member, any information or product that is designed to encourage retention of or an increase in Contracted Membership, and is produced in a variety of print, broadcast, and direct marketing media that include, but are not limited to: radio, television, billboards, newspapers, the internet, leaflets, informative materials (ex. Summary of Benefits, Approved Formulary), videos, advertisements, letters, posters, and items of nominal value.
Medicaid	The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. California's state-specific name for this program is Medi-Cal.

Term	Definition
Medicare	Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.
Medicare Part A	Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Certain conditions must be met to get these benefits.
Medicare Part B	Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.
Member	An enrollee-beneficiary of the CalOptima OneCare Connect program.
Multi-Purpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with disabilities as an alternative to nursing facility placement.
Other Health Coverage (OHC)	Evidence of health coverage other than OneCare Connect including, but not necessarily limited to 1. The CalOptima Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
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.
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.

Term	Definition
Service Area	Orange County, California, and ten (10) air miles of any portion of Orange County, California.
Share of Cost (SOC)	Medi-Cal requires some Members, based on their income, to contribute to the cost of their health care each month before Medi-Cal will pay. The amount Members must contribute is set by Medi-Cal and is called Share of Cost (SOC).
Special Enrollment Period	Election Period provided to individuals in situations where; 1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by Centers for Medicare & Medicaid Services (CMS) (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the Medicare Advantage plan; 2. CMS or the organization has terminated the Medicare Advantage organization's contract for the Medicare Advantage plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides; 3. The individual demonstrates that the Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of its contract under Medicare Advantage in relation to the individual, or the Medicare Advantage organization (or its agent) materially misrepresented the plan when marketing the plan; 4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or 5. The individual meets such other exceptional conditions as CMS may provide.
Urgent Care	Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations: 1. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment; or 2. In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Policy:	CMC.4011
Title:	**Notice of Change in Location and Availability of Covered Services**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 10/02/2020*
Effective Date:	05/01/2015
Revised Date:	10/01/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the processes by which CalOptima shall notify affected Members and other interested parties, including Sales and Marketing Vendors, of changes in the location and availability of Covered Services.

II. POLICY

A. If CalOptima changes any aspect of OneCare Connect that may impact Members, it shall notify Members as follows:

1. If the change in Covered Services shall take effect on January 1, CalOptima shall notify all Members no later than September 30 of the prior calendar year.

2. For all other changes in Covered Services, CalOptima shall notify all Members at least thirty (30) calendar days before the effective date of the change.

3. In the event of a natural disaster or emergency, CalOptima shall notify Members of any significant changes in the availability or location of Covered Services, as soon as possible.

B. Except as otherwise provided in this policy, if a contracted Health Network changes availability or location of Covered Services, CalOptima or the Health Network shall make best efforts to notify affected Members at least thirty (30) calendar days prior to the effective date of such change.

C. Upon termination of a Primary Care Provider (PCP)'s contract with a Health Network:

1. The Health Network shall notify CalOptima no later than sixty (60) calendar days prior to the PCP's contract termination date.

2. CalOptima and the Health Network shall notify affected Member, in accordance with CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification.

D. CalOptima shall submit any changes in the availability or location of Covered Services to the Centers for Medicare & Medicaid Services (CMS) and California Department of Health Care

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Services (DHCS), if applicable for review and approval, in accordance with the latest Medicare-Medicaid Plan (MMP) marketing guidelines.

E. CalOptima shall notify all interested parties of changes in the availability or location of Covered Services to ensure that accurate information is conveyed to current and prospective Members regarding the availability of Providers in each Health Network.

III. PROCEDURE

A. Subject to the provisions of this policy, a Health Network or CalOptima shall make best efforts to provide notification to Members enrolled in the Health Network at least thirty (30) calendar days prior to the effective date of a change in Covered Services.

1. In the case of unforeseen circumstances (i.e., the Health Network or CalOptima receives less than thirty (30) calendar days notice of a change in a Provider contract status), the Health Network or CalOptima shall notify Members enrolled in the Health Network of a change in the availability of a Covered Service or the location where Members may obtain Covered Services immediately upon receipt of notice of such change.

2. If a Health Network terminates a Contracted Provider's contract without prior notice as a result of his or her endangering the health and safety of Members, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the Health Network or CalOptima shall provide notice to affected Members within thirty (30) calendar days after the date of the contract termination.

3. The Health Network or CalOptima notice to Members shall include a description of the change in availability or location of Covered Services, and instructions for obtaining those Covered Services affected by the change.

B. Notice of Change in Availability or Location of Service

1. CalOptima shall provide Sales and Marketing Vendors with written notice via website, letter or mailings of any change in the availability or location of Covered Service within one (1) business day after receipt of notification of a change in Providers.

2. CalOptima shall notify all other interested parties, including but not limited to, Providers, community-based organizations, and other related health care entities, of such changes if CalOptima determines that notification ensures continuity of care for Members.

C. CalOptima shall ensure continuity of care for Members in accordance with CalOptima Policy CMC.6021: Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
B. CalOptima Policy CMC.6021: Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners

C. CalOptima Three-way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS)
D. Medicare Managed Care Manual, Chapter 11, Section 100.4: Provider and Supplier Contract Requirements
E. Medicare Managed Care Manual: CY2019 Final Medicare Marketing Guidelines
F. Medicare-Medicaid Plan (MMP) CY 2020 Marketing Guidance for California Cal MediConnect Plans (Issued: August 29, 2019)
G. Title 42, Code of Federal Regulations (CFR.), § 422.111(e)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2015	CMC.4011	Notice of Change in Location and Availability of Covered Services	OneCare Connect
Revised	08/01/2016	CMC.4011	Notice of Change in Location and Availability of Covered Services	OneCare Connect
Revised	08/01/2017	CMC.4011	Notice of Change in Location and Availability of Covered Services	OneCare Connect
Revised	08/01/2018	CMC.4011	Notice of Change in Location and Availability of Covered Services	OneCare Connect
Revised	09/01/2019	CMC.4011	Notice of Change in Location and Availability of Covered Services	OneCare Connect
Revised	10/01/2020	CMC.4011	Notice of Change in Location and Availability of Covered Services	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 Service	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.
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 the OneCare Connect program.
Non-Physician Medical Practitioner	A nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.
Primary Care Practitioner/Physician	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, physician group or other person or institution that furnishes Covered Services.
Sales and Marketing Vendor	A vendor contracted with CalOptima to provide sales and marketing functions for OneCare Connect.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Authorizing Modifications to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

Approve modifications to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks

Background

CalOptima establishes new and modifies existing policies and procedures to implement federal and state laws, regulations, contracts, and business practices. In addition, CalOptima staff performs an annual policy review to update internal policies and procedures to ensure compliance with applicable requirements.

Discussion

Staff recommends revisions to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks. This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to health networks, including HMOs, Physician Hospital Consortia (PHC), and Shared Risk Groups (SRG).

Proposed revisions to this policy include:

- Identifying that claims will be at 100% of the amount paid if Medi-Cal has no value for the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code or other code as assigned by the California Department of Health Care Services (DHCS)
- Clarifying that, should a value be assigned following repricing but before final settlement of any given measurement period, CalOptima will reevaluate the value assigned in the retrospective risk corridor period; and
- Changing the Medi-Cal Rx implementation date to identify that it will be no sooner than April 1, 2021.

Fiscal Impact

The recommended action to approve revisions to CalOptima Policy FF.4000 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

The recommended action is expected to enhance the efficiency of CalOptima's operations and governance and ensure compliance with applicable regulatory requirements.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. CalOptima Policy FF. 4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks (redlined and clean)

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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Policy:	FF.4000
Title:	**Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department:	Finance
Section:	Accounting
CEO Approval:	
Effective Date:	07/01/2019
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortia (PHC), and Shared Risk Groups (SRG).

II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the terms and conditions of this Policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as identified by the local CCS Program, enrolled in Health Networks during the applicable period.

C. If the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima shall recover payments made to the Health Network for such individual.

D. CalOptima Direct-Administrative (COD-A) is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Policy FF.1007: Health Network Reinsurance Coverage, CalOptima shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

F. The Measurement Period for WCM payments is established by fiscal year (FY), July 1 to June 30. In accordance with Section II.J.3 of this Policy, CalOptima shall keep each Measurement Period (FY1) open for thirty (30) months after the end of each Measurement Period before the risk corridor reconciliation is considered finalized (e.g., Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, 2022).

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G. CalOptima reimburses Health Networks, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

H. CalOptima shall reimburse Kaiser for services rendered to enrolled CCS-eligible Members based on a methodology described in Section III.G. of this Policy.

I. CalOptima may adjust Health Network initial Capitation Payment rates subject to Department of Health Care Services (DHCS) funding updates for the Measurement Period.

J. The WCM payment timelines are:

1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth (15th) calendar day of the month.

2. Interim catastrophic payment: CalOptima shall pay quarterly based on the refreshed data for each Measurement Period as follows:

CCS Eligible and Claims Incurred for Dates of Service	Claims Payment Period	Interim Catastrophic Calculation (Payment/ Recoupment) Date
July 1 – September 30, FY1	FY1 paid through September 30, FY1	No later than November 30, FY1
July 1 – December 31, FY1	FY1 paid through December 31, FY1	No later than February 28, FY1
July 1 – March 31, FY1	FY1 paid through March 31, FY1	No later than May 31, FY1
July 1 – June 30, FY1	FY1 paid through June 30, FY1	No later than August 31, FY2
July 1 – June 30, FY1	FY1 paid through September 30, FY2	No later than November 30, FY2

3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the refreshed data for each Measurement Period as follows:

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 6 months: FY1 paid through December 31, FY2	No later than May 15, FY2
July 1 – June 30, FY1	Measurement Period plus 18 months: FY1 paid through December 31, FY3	No later than May 15, FY3

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 30 months (final): FY1 paid through December 31, FY4	No later than May 15, FY4

III. PROCEDURE

A. Initial Capitation Payment

1. CalOptima shall provide monthly Capitation Payments for CCS-eligible Members enrolled in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima, approved by the BOD and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Payment

1. Health Networks shall submit paid claims through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all Open Measurement Periods. Health Networks shall submit claims using CalOptima's proprietary format and file naming convention.

   a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at ~~fifty~~one hundred percent (~~50~~100%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. Should a value be assigned following the repricing of these claims prior to the final settlement of any given measurement period, CalOptima will utilize that value for the five (5)-digit numerical CPT code, HCPCS code, or other code as assigned by DHCS in the Retrospective Risk Corridor discussed in Section III.C. These allowable claims, as determined by CalOptima, shall represent the repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for missing information or incorrect data. If CalOptima rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth (15th) of the month will be included in the subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted by an eligible Health Network after the September 30, FY2 deadline will be processed in accordance with the requirements of the annual retrospective risk corridor reconciliation as set forth in Sections II.J.3 and III.C of this Policy.

5. For a complete claims paid file accepted by CalOptima, CalOptima shall notify an eligible Health Network of the results as follows:

    a. If CalOptima receives the file by the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of that month.

    b. If CalOptima receives the file after the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent month.

6. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima's quarterly interim catastrophic payment remittance advice.

    a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:

        WCMReimb@caloptima.org

        Or by U.S. mail to:

        Attn: Coding Initiatives Department - WCM Claims
        CalOptima
        505 City Parkway West
        Orange CA 92868

    b. An appeal claims submission file shall only include specific claims to be reconsidered.

    c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

    d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within three (3) business days after receipt of the appeal file.

        i. CalOptima may reject a file for any missing information or incorrect data.

ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

e. CalOptima shall process an appeal and provide an eligible Health Network with the detailed report and payment, if applicable, on the following quarterly reimbursement period or within forty-five (45) business days after receipt of the appeal, whichever is later.

7. For each CCS-eligible Member in a given Measurement Period, CalOptima shall reimburse at one hundred percent (100%) of the repriced amount for the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

a. $17,000 for covered physician expenses; and

b. $150,000 for covered hospital expenses.

8. CalOptima shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

b. The CEO and CFO will make a final determination. CalOptima Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the December claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all Open Measurement Periods.

2. CalOptima shall validate and reprice the submitted claims, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at ~~fifty~~one hundred percent (~~50~~100%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS~~.~~ within the retrospective risk corridor period. These allowable claims, as determined by CalOptima, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician capitation and hospital capitation separately.

   a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable Measurement Period.

   b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

Threshold	CalOptima's Risk/Surplus Share
> 115%	95%
115%	90%
105%	75%
102%	50%
100%	0%
98%	50%
95%	75%
85%	90%
< 85%	100%

   c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

   d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

   e. Administrative and medical management components of CCS reimbursement will be based on total reimbursement at the established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the initial Capitation Payment, interim catastrophic reimbursement, and retrospective risk corridor settlements. The established percentage shall be the administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than March 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

8. In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Claims Administration Department will review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

    b. The CEO and CFO will make a final determination. CalOptima will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing adjustments will be included in the next interim catastrophic payment or annual retrospective risk corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the interim catastrophic payment or annual retrospective risk corridor reconciliation after utilizing the dispute process set forth in this Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Effective upon the implementation of Medi-Cal Rx, no sooner than ~~January~~April 1, 2021, pharmacy expenses for services rendered to enrolled CCS-eligible Kaiser Members, including Hepatitis C drug therapy, shall be excluded from this Policy and shall not be subject to reimbursement as described in Sections III.G.3 through III.G.5 of this Policy.

3. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed by CalOptima and Kaiser. Kaiser shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima and Kaiser.

    a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.G.5.

4. CalOptima shall validate and reprice the submitted claims based on:

    a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima contracted Pharmacy Network rate;

    b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services with CalOptima), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule. CalOptima updates the CalOptima Medi-Cal Fee Schedule in accordance with CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Medi-Cal Fee Schedule in effect on the date of service;

    c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule; and

    d. For non-Kaiser system pharmacy and other services, CalOptima shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

5. Repricing Results and Reconciliation

    a. CalOptima shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima's receipt of the complete claims paid file.

    b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

    c. CalOptima, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

    d. CalOptima shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

    e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

H. If a Health Network identifies an Overpayment of WCM payments, a Health Network shall return the Overpayment within sixty (60) calendar days after the date on which the Overpayment was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the Overpayment.

1. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the Overpayment no later than three (3) business days after receipt.

2. CalOptima shall coordinate with a Health Network on the process to return the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy FF.1001: Capitation Payments
D. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
E. CalOptima Policy FF.1007: Health Network Reinsurance Coverage
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayment to Providers

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/02/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2019	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	12/03/2020	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	TBD	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Direct-Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include all applicable DHCS Medi-Cal Managed Care Division Policy Letters and All Plan letters, and any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) ~~or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.~~a physician group under a shared risk contract, or an HMO.
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, 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), 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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange
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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled to that Health Network.
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.
Measurement Period	The Fiscal ~~year~~Year spanning July 1 to June 30. Each Measurement Period will remain open until the third annual report is issued to the Health Network.
~~Open Measurement Period~~	~~The measurement year will remain open until the third annual report is issued to health network~~
Overpayment	Any payment made by CalOptima to a ~~provider~~Provider to which the ~~provider~~Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for enrolled Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Policy:	FF.4000
Title:	**Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department:	Finance
Section:	Accounting
CEO Approval:	
Effective Date:	07/01/2019
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortia (PHC), and Shared Risk Groups (SRG).

II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the terms and conditions of this Policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as identified by the local CCS Program, enrolled in Health Networks during the applicable period.

C. If the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima shall recover payments made to the Health Network for such individual.

D. CalOptima Direct-Administrative (COD-A) is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Policy FF.1007: Health Network Reinsurance Coverage, CalOptima shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

F. The Measurement Period for WCM payments is established by fiscal year (FY), July 1 to June 30. In accordance with Section II.J.3 of this Policy, CalOptima shall keep each Measurement Period (FY1) open for thirty (30) months after the end of each Measurement Period before the risk corridor reconciliation is considered finalized (e.g., Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, 2022).

Back to Agenda Back to Item

G. CalOptima reimburses Health Networks, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

H. CalOptima shall reimburse Kaiser for services rendered to enrolled CCS-eligible Members based on a methodology described in Section III.G. of this Policy.

I. CalOptima may adjust Health Network initial Capitation Payment rates subject to Department of Health Care Services (DHCS) funding updates for the Measurement Period.

J. The WCM payment timelines are:

1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth (15th) calendar day of the month.

2. Interim catastrophic payment: CalOptima shall pay quarterly based on the refreshed data for each Measurement Period as follows:

CCS Eligible and Claims Incurred for Dates of Service	Claims Payment Period	Interim Catastrophic Calculation (Payment/ Recoupment) Date
July 1 – September 30, FY1	FY1 paid through September 30, FY1	No later than November 30, FY1
July 1 – December 31, FY1	FY1 paid through December 31, FY1	No later than February 28, FY1
July 1 – March 31, FY1	FY1 paid through March 31, FY1	No later than May 31, FY1
July 1 – June 30, FY1	FY1 paid through June 30, FY1	No later than August 31, FY2
July 1 – June 30, FY1	FY1 paid through September 30, FY2	No later than November 30, FY2

3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the refreshed data for each Measurement Period as follows:

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 6 months: FY1 paid through December 31, FY2	No later than May 15, FY2
July 1 – June 30, FY1	Measurement Period plus 18 months: FY1 paid through December 31, FY3	No later than May 15, FY3

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 30 months (final): FY1 paid through December 31, FY4	No later than May 15, FY4

III. PROCEDURE

A. Initial Capitation Payment

1. CalOptima shall provide monthly Capitation Payments for CCS-eligible Members enrolled in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima, approved by the BOD and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Payment

1. Health Networks shall submit paid claims through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all Open Measurement Periods. Health Networks shall submit claims using CalOptima's proprietary format and file naming convention.

   a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at one hundred percent (100%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. Should a value be assigned following the repricing of these claims prior to the final settlement of any given measurement period, CalOptima will utilize that value for the five (5)-digit numerical CPT code, HCPCS code, or other code as assigned by DHCS in the Retrospective Risk Corridor discussed in Section III.C. These allowable claims, as determined by CalOptima, shall represent the repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for missing information or incorrect data. If CalOptima rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth (15th) of the month will be included in the subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted by an eligible Health Network after the September 30, FY2 deadline will be processed in accordance with the requirements of the annual retrospective risk corridor reconciliation as set forth in Sections II.J.3 and III.C of this Policy.

5. For a complete claims paid file accepted by CalOptima, CalOptima shall notify an eligible Health Network of the results as follows:

    a. If CalOptima receives the file by the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of that month.

    b. If CalOptima receives the file after the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent month.

6. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima's quarterly interim catastrophic payment remittance advice.

    a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:

        WCMReimb@caloptima.org

        Or by U.S. mail to:

        Attn: Coding Initiatives Department - WCM Claims
        CalOptima
        505 City Parkway West
        Orange CA 92868

    b. An appeal claims submission file shall only include specific claims to be reconsidered.

    c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

    d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within three (3) business days after receipt of the appeal file.

        i. CalOptima may reject a file for any missing information or incorrect data.

ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

e. CalOptima shall process an appeal and provide an eligible Health Network with the detailed report and payment, if applicable, on the following quarterly reimbursement period or within forty-five (45) business days after receipt of the appeal, whichever is later.

7. For each CCS-eligible Member in a given Measurement Period, CalOptima shall reimburse at one hundred percent (100%) of the repriced amount for the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

   a. $17,000 for covered physician expenses; and

   b. $150,000 for covered hospital expenses.

8. CalOptima shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

    b. The CEO and CFO will make a final determination. CalOptima Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the December claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all Open Measurement Periods.

2. CalOptima shall validate and reprice the submitted claims, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at one hundred percent (100%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS within the retrospective risk corridor period. These allowable claims, as determined by CalOptima, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician capitation and hospital capitation separately.

   a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable Measurement Period.

   b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

Threshold	CalOptima's Risk/Surplus Share
> 115%	95%
115%	90%
105%	75%
102%	50%
100%	0%
98%	50%
95%	75%
85%	90%
< 85%	100%

   c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

   d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

   e. Administrative and medical management components of CCS reimbursement will be based on total reimbursement at the established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the initial Capitation Payment, interim catastrophic reimbursement, and retrospective risk corridor settlements. The established percentage shall be the administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than March 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

8. In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Claims Administration Department will review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

    b. The CEO and CFO will make a final determination. CalOptima will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing adjustments will be included in the next interim catastrophic payment or annual retrospective risk corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the interim catastrophic payment or annual retrospective risk corridor reconciliation after utilizing the dispute process set forth in this Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Effective upon the implementation of Medi-Cal Rx, no sooner than April 1, 2021, pharmacy expenses for services rendered to enrolled CCS-eligible Kaiser Members, including Hepatitis C drug therapy, shall be excluded from this Policy and shall not be subject to reimbursement as described in Sections III.G.3 through III.G.5 of this Policy.

3. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed by CalOptima and Kaiser. Kaiser shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima and Kaiser.

    a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.G.5.

4. CalOptima shall validate and reprice the submitted claims based on:

    a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima contracted Pharmacy Network rate;

    b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services with CalOptima), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule. CalOptima updates the CalOptima Medi-Cal Fee Schedule in accordance with CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Medi-Cal Fee Schedule in effect on the date of service;

    c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule; and

    d. For non-Kaiser system pharmacy and other services, CalOptima shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

5. Repricing Results and Reconciliation

    a. CalOptima shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima's receipt of the complete claims paid file.

    b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

    c. CalOptima, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

    d. CalOptima shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

    e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

H. If a Health Network identifies an Overpayment of WCM payments, a Health Network shall return the Overpayment within sixty (60) calendar days after the date on which the Overpayment was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the Overpayment.

1. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the Overpayment no later than three (3) business days after receipt.

2. CalOptima shall coordinate with a Health Network on the process to return the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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G. DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayment to Providers

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/02/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include all applicable DHCS Medi-Cal Managed Care Division Policy Letters and All Plan letters, and any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) a physician group under a shared risk contract, or an HMO.
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, 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), 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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange

Term	Definition
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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled to that Health Network.
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.
Measurement Period	The Fiscal Year spanning July 1 to June 30. Each Measurement Period will remain open until the third annual report is issued to the Health Network.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for enrolled Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Brigette Hoey, Executive Director, Human Resources, (714) 246-8405
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Recommend approval of the proposed Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan

Background

In 1994, the CalOptima Board of Directors approved the establishment of a deferred compensation program (Program) for employees under Section 457(b) of the Internal Revenue Code, including a deferred compensation plan (Plan). Due to changes in Section 457 over the years, an amended and restated Plan was adopted in 2005. A subsequent amended and restated Plan was adopted in 2011 that provided for the rights of designated beneficiaries who are not the employee's spouse in the event of the death of the employee. A subsequent amended and restated Plan was adopted in 2013 that: (1) added a Roth 457 option (Roth Option) under the Plan; (2) established the composition of the CalOptima Deferred Compensation Committee (Committee) to include the Executive Director of Human Resources as Committee Chair, and the Chief Financial Officer or designee, as well as additional members and future replacement members appointed by the Committee Chair; and (3) directed the Committee to follow the "prudent person" standard generally applicable to California government retirement plans in selection of investment options for the Deferred Compensation Investment Policy (Investment Policy).

Discussion

The Committee, in consultation with CalOptima's independent investment advisor SageView Advisory Group, LLC, prepared the proposed Investment Policy Statement, which is intended to establish the policies and guidelines for CalOptima's Plan and to assist the Committee in effectively selecting, monitoring, and evaluating investment alternatives made available to Plan participants. The Investment Policy Statement outlines and prescribes a prudent and acceptable investment philosophy and sets out the investment management procedures.

The Board delegated authority to the Committee to interpret the Plan and adopt rules and regulations for the administration of the Plan, and to interpret, alter, amend, or revoke any rules and regulations so adopted, provided that they are not inconsistent with the provisions of the Plan and that they conform with Section 457(b) of the Code and any applicable regulations thereunder.

For oversight and transparency purposes, the Committee recommends that the initial adoption of the Investment Policy Statement be reviewed and approved by the FAC and recommended for approval by

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the Board. Staff will return to the FAC and Board with any future substantive revisions to the Investment Policy Statement for review and approval.

Fiscal Impact

The recommended action to approve the Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Adoption of the proposed Investment Policy Statement will establish the policies and guidelines for the administration of the Plan. Bringing the Investment Policy Statement to the FAC and the Board for review and adoption provides oversight and transparency desired by the Committee.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Investment Policy Statement

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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INVESTMENT POLICY STATEMENT

Orange County Health Authority dba CalOptima
Orange County Health Authority 457(b) Deferred Compensation Plan

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Purpose of the Investment Policy Statement

This Investment Policy Statement establishes the policies and guidelines for the Orange County Health Authority 457(b) Deferred Compensation Plan (the "Plan") and is intended to assist the CalOptima Deferred Compensation Committee (the "Committee") in effectively selecting, monitoring and evaluating investment alternatives made available to participants under the Plan. It outlines and prescribes a prudent and acceptable investment philosophy and sets out the investment management procedures.

Purpose of the Plan

The Plan was established to provide a retirement savings program for eligible employees of the Orange County Health Authority dba CalOptima (the "Plan Sponsor"). The Plan is maintained for the exclusive purpose of benefiting the Plan participants and their beneficiaries. The Plan intends to operate in accordance with all applicable state and federal laws and regulations.

The goal of the Plan is to provide a framework for eligible employees of the Plan Sponsor to establish a savings and investment program for their retirement. While Plan participants are ultimately responsible for their own investment decisions, the Plan Sponsor will endeavor to provide an appropriate range of investment alternatives, allowing each individual participant to invest in accordance with his or her own time horizons, risk tolerance, and retirement goals.

In evaluating the investment alternatives for the Plan, the Plan Sponsor will take into account all Plan demographics.

The objective of the Plan is specifically intended to:

- Promote retirement savings while encouraging employee participation as a vehicle to accumulate assets to provide for a portion of their retirement needs
- Provide Plan participants with a wide and suitable range of asset categories and investment alternatives that are intended to help participants meet their retirement goals and investment objectives
- Attract and retain outstanding employees by providing diverse investment options
- Obtain Plan investment alternatives at reasonable costs and control overall investment related service costs
- Establish investment objectives and standards for the investment options offered to assure that the assets are managed in accordance with the investment policy
- Establish formal criteria and process to evaluate investment performance results

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- Provide formal process for reviewing and modifying the investment policy; and
- Meet the fiduciary responsibility of the Deferred Compensation Plan.

Statement of Responsibilities

The following parties associated with the Plan, appointed by the Plan Sponsor, shall discharge their respective responsibilities in accordance with all applicable fiduciary standards as follows: (1) in the sole interest of the Plan participants and beneficiaries; and (2) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and of like aims. All Plan fiduciaries shall complete education and ethics training that covers all aspects of their duties and responsibilities as fiduciaries of the Plan, including, but not limited to, best practices, plan compliance, legislative and regulatory activities, as well as investment alternative selection, monitoring and replacement.

A. Deferred Compensation Committee: The members of the Committee are Plan fiduciaries and supervise the investment of the assets of the Plan, and make decisions concerning investment alternatives available under the Plan. In adopting this Investment Policy Statement, it is the intention of the Committee that the oversight of the investment portion of the Plan will be the responsibility of the Committee. The Committee will follow best practices, which include, but may not be limited to, the Duty of Loyalty, the Duty of Prudence, the Duty to Diversify, and the Duty to Follow the Plan Documents. The Committee shall be responsible for the Plan- level investment selection process, as set forth in this Investment Policy Statement, but is not responsible for the individual fund performance and does not guarantee positive investment results. The Committee may select a qualified Investment Consultant whose duties may include assisting in the selection, evaluation, monitoring of investment options and other administrative issues.

B. Trustee: The Trustee of the Plan is charged with safekeeping the securities as well as collecting and disbursing the Plan assets and periodic accounting statements.

C. Recordkeeper: The Recordkeeper has responsibilities that include, but are not limited to, the following: maintaining participant records, administering participant directions, reporting to the Plan Sponsor, reporting to participants, allocating contributions, administering loans, and preparing the required regulatory documents.

D. Investment Consultant: If Plan Sponsor elects to use an Investment Consultant, the Investment Consultant is charged with the responsibility of advising the Committee

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on investment policy, advising on the selection of investment alternatives, providing performance analysis and monitoring services, and educating the Committee on economic and investment trends that may impact the performance of the selected and available investment alternatives. The Investment consultant shall evaluate changes in legislation and regulations to ensure compliance regarding investment matters. The Investment Consultant, along with the Committee, shall be responsible for the Plan-level investment selection process, as set forth in this Investment Policy Statement, but is not responsible for the individual fund performance and does not guarantee investment results.

Investment Choices

The Plan intends to provide a broad range of investment alternatives. This includes having, at a minimum, three diversified investment alternatives that are sufficient in permitting the participants to select from a broad range of risk and return characteristics that will give participants the opportunity to develop an investment portfolio which will meet their desired risk and return requirements. Diversification, however, does not ensure a profit or protect against loss in a declining market.

All investment choices will be publicly available mutual funds, institutional trusts, or similar vehicles. All investments being offered will fluctuate in value with market conditions and, when redeemed, may be worth more or less than the amount originally invested. The chosen investment alternatives will be selected on the basis of their compatibility with Plan participants' needs and regulatory recommendations. Each of the chosen investment alternatives will be designed to follow a specific stated investment objective.

Qualified Default Investment Alternative (ODIA}

Although the Committee intends that participants will direct the investment of their assets held under the Plan, there may be circumstances under which participants do not provide direction regarding the investment of their individual accounts. In such instances, participant accounts will be invested in the Plan's default investment alternative. The Committee's intention is for the Plan to comply with the Pension Protection Act of 2006 by offering a default investment alternative that complies with all of the conditions required of a Qualified Default Investment Alternative (QDIA).

The Committee may elect to utilize a multi-asset class investment alternative, such as age-appropriate target-date funds, as the QDIA. Periodically, as participant demographics or market conditions require, the Committee shall review and document the process for monitoring and selecting the QDIA, taking into account such factors as the philosophy and goals of the Plan Sponsor as well as the needs and abilities of the participants and beneficiaries.

The specific target date portfolio for a participant or beneficiary who fails to make an investment election will be based on the participant's or beneficiary's date of birth and

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an assumed normal retirement date of age 65.

Selection of Investment Alternatives

The Plan will take a two-tiered approach to Investment alternative selection. Quantitative and qualitative screens are used as follows:

Quantitative Screening (including but not limited to):

- Investment track record
- Investment risk
- Investment risk/return
- Investment style analysis
- Performance consistency
- Investment cost
- Turnover ratio

Qualitative Screening (Investments that pass the quantitative screens will be reviewed for characteristics that include but are not limited to):

- Investment-style variations
- Portfolio concentration
- Asset size and growth

Interviews with portfolio managers and/or analysts will also be conducted if deemed necessary.

Selected alternatives will be reviewed to ensure that there are no additional factors that would make them unsuitable for inclusion in the Plan. Each alternative will also be examined to ensure that it appropriately complements the overall diversification and risk and return parameters of the entire Plan investment lineup.

In addition to diversification and risk tolerance considerations, investment expenses will be considered in the selection of investment alternatives. The Committee will regularly review all costs associated with the management of the Plan's investment program. These costs include the following:

- Expense ratios of each investment alternative against the appropriate peer group.
- Trustee and custodial fees for holding assets, collecting income, and paying disbursements.
- Plan administrative fees, including record keeping fees and other fees associated with services the Plan receives, such as compliance testing fees, audit fees, fees for communication services, etc.

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Evaluation Methodology

The Committee anticipates using the following criteria in selecting and monitoring Plan investment alternatives. Each Plan investment alternative should be evaluated on an ongoing basis using several measures that quantify the expenses, returns and risk-adjusted performance of each investment alternative within its peer group.

Each Plan investment alternative should be reviewed at least annually against its peer group and benchmark index to assess the performance and quality of each offering. The list of criteria that may be used for evaluation is included as Appendix B of this document and may be updated by the Committee, as necessary.

As noted in Appendix A, whenever possible, each investment alternative is benchmarked to a specific market index, and performance is evaluated and compared to a relevant peer group using Morningstar category classifications. Each criterion for an investment alternative is given a peer group ranking, shown as a percentage. As an example, a criterion ranking of 10% indicates an investment alternative is in the top 10% of its peer group for said criterion. The rankings for all criteria are then weighted and averaged to give an investment alternative its average ranking score. The lower the average ranking score, the better. In general, an investment alternative with an average ranking score of 25% would be more attractive than a comparable investment alternative with a ranking score of 50%. An overall ranking score is used to indicate where an investment alternative places in relation to the scores of the other investment alternatives in its category. Generally, investment alternatives are divided into categories of deciles and quartiles.

Peer group rankings require a three-year history to ensure an accurate evaluation of the investment alternative. Any investment alternative with fewer than three years of history will not be evaluated using this method. In the event there is a sufficiently similar investment alternative, the Committee may elect to use its history for evaluation purposes. Sufficiently similar investment alternatives may include:

- Alternate share classes of the same product.
- Other products, such as collective investment trusts (CITs), separate accounts or recordkeeper sub-advised investment alternatives, that are managed by the same portfolio management team according to a substantially similar investment strategy.

In addition to the quantitative methodology described above, many qualitative criteria and possible warning signs are monitored to highlight an investment alternative's potential exposure to risk that may make it unsuitable as a retirement Plan investment

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option. The warning signs may include (but are not limited to):

- Above-average operating expenses
- Above-average style drift (as determined by returns-based and holdings-based analyses)
- High degrees of portfolio concentration among individual holdings
- High degrees of portfolio concentration among economic sectors
- Above-average performance volatility
- Above-average portfolio turnover
- Below-average Alpha
- Below-average manager tenure and/or above-average turnover
- Rapid growth in assets
- Significantly positive or negative cash flows
- Unusual levels of corporate scrutiny; poor public perception
- For bond portfolios, very low average credit quality relative to peers
- For bond portfolios, significantly above- or below-average portfolio durations
- Recent changes to or concerns with the firm structure/ ownership
- Recent changes to or concerns with the corporate management team structure

Other Investment Evaluation Criteria

The Committee recognizes that certain investment alternatives present challenges in monitoring, given the nature of the investment alternative's portfolio and peer group. Thus, there are several instances where Investment alternatives will not fit neatly into the monitoring framework set forth herein. Therefore, the Committee must consider additional or different factors when evaluating certain investments. The following are common examples of investments requiring a different point of view, whether the Committee has included them In the current menu or may consider doing so in the future.

Multi-asset class *investments:* For multi-asset class investment alternatives, such as target-date funds, the asset allocation and glide path should be evaluated taking into account factors such as generally accepted investment theories and prevailing investment industry practices, and goals of the plan, the philosophy of the fiduciaries regarding asset class diversification and the desired relationship of risk (or volatility) and potential return, and the needs and abilities of the participants and beneficiaries. The Committee, with the assistance of the Investment Consultant, expects to engage in a process to identify and consider those goals, preferences, needs and abilities and to select a default investment consistent with that analysis.

As the process for comparing multi-asset class investments, including target-date funds, differs from the process used for other investment selections in several respects. Criteria listed elsewhere in this Investment Policy Statement may not apply.

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Index fund: The goal of an index fund is to closely mirror the performance of a predetermined index at a reasonable cost. The criteria which may be used to evaluate index funds is set forth in Appendix C and may be updated from time-to-time at the Committee's discretion.

Each index fund will be compared to a standard index for its respective category classification and assigned a ranking in each of the four criterions. The rankings for all criteria are then weighted and averaged to give an investment alternative its average ranking score. Index funds with an average ranking score in the top 75% of the investment alternative's in a category are given a passing score ("Pass"), while investment alternatives below in the lowest 25% of investment alternatives are given a failing score ("Fail").

Stable value investments: The goal of a stable value fund is to preserve capital. Stable value investments come in several structures: pooled/comingled funds, insurance separate accounts, and guaranteed investment contracts (GICs)/insurance general accounts or derivatives thereof.

One investment characteristic of these products is their investment in various sectors of the bond market. Thus, part of the evaluation will hinge on the evaluation of the underlying bond portfolio. The other important characteristic is financial credit worthiness of the insurance companies that issue wrap contracts to protect the book value of the bond portfolios. Some additional unique (albeit not exhaustive) metrics and characteristics that warrant evaluation include market-to-book value ratio, participant /plan sponsor withdrawal restrictions, crediting rate and wrap structure. For insurance general accounts, the Committee should at a minimum review the crediting rate, withdrawal restrictions, and credit worthiness ratings of the insurer.

Monitoring of Investment Policy and Investment Performance

The Committee, with the assistance of the Investment Consultant, will review the Plan's Investment Policy and monitor each investment alternative on an ongoing basis. The Committee will periodically evaluate the investment results of the investment alternatives.

In addition, the Committee shall maintain a "Watch List" for investment alternatives that are not meeting certain objectives. An investment alternative will be placed on the Watch List if it meets either at least two of the conditions “a” through “g” below or condition “h”:

a. Performance below 50% of its peer group for a three-year period
b. Performance below 50% of its peer group for a five-year period
c. Performance below 50% of its peer group for a ten0year period
d. Performance below its benchmarks for a three-year period
e. Performance below its benchmarks for a five-year period

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f. Performance below its benchmarks for a ten-year period
g. A Morningstar rating of 2 or below
h. Extenuating circumstances, such as:

    1. Change in fees
    2. Change of portfolio manager
    3. Change of sub-advisor
    4. Any violations of SEC rules or regulations
    5. Performance will be considered over a minimum of a three-year period and a maximum of a ten-year period unless a shorter-term underperformance is so severe that it warrants the Committee's immediate consideration for removal.

Investment alternatives that fail to meet qualitative criteria {i.e.: manager changes, fund company reorganizations, strategy changes) will be put on the Watch List by the Committee.

To be in good standing and removed from the Watch List, an investment alternative must not have more than one of the Watch List criteria "a" through "g" above. However, an investment alternative may have extenuating circumstances that warrants continuation on the Watch List.

The Committee shall have the authority to establish, modify, amend, or adjust acceptable performance measurement standards by which each investment alternative is to be evaluated.

Final selection, replacement and/or removal of an investment alternative shall be completed only after conducting a thorough review of the identified investment alternative.

An investment alternative on the Watch List will be removed from participant investment options if it is determined that extenuating circumstances are not in accordance with prudent investment standards or when conditions "a" through "e" below apply:

a. Performance below 50% of its peer group for a five-year period
b. Performance below 50% of its peer group for a ten-year period
c. Performance below its benchmarks for a five-year period
d. Performance below its benchmarks for a ten-year period
e. A Morningstar rating of 2 or below
f. Extenuating circumstances, such as:
    1. Change in fees
    2. Change of portfolio manager
    3. Change of sub-advisor
    4. Any violations of SEC rules or regulations
    5. Performance will be considered over a minimum of a three-year period and a maximum of a ten-year period unless a shorter-term underperformance is so severe that it warrants the Committee's immediate consideration for removal.

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The Committee has discretion to retain any investment alternative if it remains a prudent option.

The Recordkeeper will communicate to all eligible participants the investment alternative(s) subject to removal.

After an investment alternative is removed, all existing balances and future contributions will be moved from the removed investment alternative to a similar existing investment alternative or a replacement fund. No new contributions or transfers will be accepted into a removed investment alternative.

The Plan will provide for regular communication of investment and Plan information in addition to necessary updates to inform participants of changes to the Plan. The Plan will not be responsible for providing investment advice to participants.

Proxy Voting

Should the Committee elect to participate in a proxy vote, the Committee shall be required to provide a detailed analysis of voting activities on an annual basis (calendar year). When voting proxies, the Committee will vote to the best of their abilities in the best interest of the Plan's participants. The Committee is not required to participate in all proxy votes related to the investments in the Plan. Investment Consultant is able to offer general guidance and provide clarification with respect to the process of voting by proxy but will not be responsible for making vote decisions.

Note: The *provisions* of *this Investment Policy Statement* are *guidelines only. The fiduciaries* are *not required to follow them. Instead, fiduciaries* are *expected to* exercise *independent judgment for the benefit of the participants.*

Review and Revisions

The Committee reserves the right to amend the Investment Policy Statement at any time it deems such amendment to be necessary or to comply with changes in applicable law as these changes affect the investment of the Plan's assets. Until revised or amended by the Committee, the Investment Policy Statement shall remain in effect.

If there is any conflict between the Investment Policy Statement and the Plan, the terms and conditions of the Plan will control.

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ADOPTION

CalOptima Deferred Compensation Committee Members:

x_____

(Print Name) (Date)

x._____

(Print Name) (Date)

x._____

(Print Name) (Date)

x_____

(Print Name) (Date)

x._____

(Print Name} (Date)

x_____

(Print Name) (Date)

x_____

(Print Name) (Date)

APPENDIX A- Categories and Benchmarks

Investment categories are defined based on their Morningstar category classifications, which also serve as the peer groups against which investment are assessed. The following list of investment categories and their corresponding benchmarks which may be used in the investment alternative evaluation process, includes but is not limited to:

Investment Alterative	***Benchmark</Index***
Money Market-Taxable	BofAML US Treasury Bill 3 Mon TR USD
Stable Value	Hueler Stable Value Index
Guaranteed Account	Hueler Stable Value Index
Bond	
Ultrashort Bond	Bloomberg Barclays US Govt/Credit 1-3 Yr TR USD
Short-Term Bond	Bloomberg Barclays US Govt/Credit 1-3 Yr TR USD
Short Government	Bloomberg Barclays Government 1-5 Yr TR USD
Intermediate Government	Bloomberg:(Barclays US Govt/Mortgage TR USD
Intermediate Core Bond	Bloomberg Barclays US Aee Bond TR USO
Intermediate Core Plus Bond	Bloomberg Barclays US Ar!.2 Bond TR USO
Long Government	Bloomberg Barclays US Government Long TR USD
Long-Term Bond	Bloomberg Barclays US Govt/Credit Long TR USO
Inflation-Protected Bond	Bloomberg Barclays US Treasury US TIPS TR USO
Corporate Bond	Bloomberg Barclavs US Credit TR USD
Multisector Bond	Bloomberg Barclays US Agg Bond TR USO
High Yield Bond	Bloomberg Barclays US HY 2% Issuer Cap TR USO
Bank Loan	Credit Suisse Leveraged Loan TR USD
World Bond	Bloomberg: Barclays Global-Aggregate TR USO
Emerging Markets Bond	JPM EMBI Global TR USO
Nontraditional Bond	Wilshire Liquid Alts TR
LargeCa1J	
Large Value	Russell 1000 Value TR USO
Large Blend	S&P 500 Index Russell 3000 Index CRSP U.S. Total Market Index
Large Growth	Russell 1000 Growth TR USO
Mid-Cap	
Mid-Cap Value	Russell Mid Cap Value TR USO

Mid-Cap Blend	Russell Mid Cap TR USO S&P Mid Cap 400 Index MSCI U.S. Mid Cap 450 Index CRSP U.S. Mid Cap Index S&P Completion Index DJ US Completion Total Stock Market Index
Mid -Cap Growth	Russell Mid Cap Growth TR USO
Small-Cap	
Small Value	Russell 2000 Value TR USO

Investment Alternative	***Benchmark/Index***
Small Cap Blend	Russell 2000 TR USO S&P Small Cap 600 Index MSCI U.S. Small Cap 1750 Index CRSP U.S. Small Cap Index
Small Growth	Russell 2000 Growth TR USO
World Stock	
World Stock	MSCI ACWI NR USO
International	
Foreign Large Value	MSCI ACWI ex USA Value NR USO
Foreign Large Blend	MSCI ACWI ex USA NR USO
Foreign Large Growth	MSCI ACWI ex USA Growth NR USO
Foreign Small/ Mid Value	MSCI ACWI ex USA SMID Value NR USO
Foreign Small/ Mid Blend	MSCI ACWI ex USA SMID NR USO
Foreign Small/ Mid Growth	MSCI ACWI ex USA SMID Growth NR USO
Diversified Emerging Markets	MSCI EM NR USO
Target Date	
Target Date	S&P Target Date Indexes
Risk-base/Hybrid	
Allocation-15% to 30% Equity	23% Russell 3000 TR USD/77% Bloomberg Barclays US Agg Bond TR USO
Allocation-30% to 50% Equity	40% Russell 3000 TR USD/60% Bloomberg Barclays US Agg. Bond TR USO
Allocation 50% to 70% Equity	60% Russell 3000 TR USO/40% Bloomberg Barclays US Agg Bond TR USO
Allocation- 70% to 85% Equity	78% Russell 3000 TR USD/22% Bloomberg Barclays US Agg Bond TR USO
Allocation-8 5%+ Equity	93 % Russell 3000 TR USD/7% Bloomberg Barclays US Agg Bond TR USO
World Allocation	60% MSCI ACWI NR/40% Bloomberg Barclays Global Agg TR
Specialty	
Real Estate	FTSE NAREIT Equity REITs TR USO
Global Real Estate	FTSE EPRA/NAREIT Developed NR USO
Commodities Broad Basket	Bloomberg Commodity TR USO
Long-Short Equity	Barclay Hedge Fund Index
Market Neutral	BofAML US Treasury Bill 3 Mon TR USO
Multi-alternative	Wilshire Liquid Alts TR
Natural Resources	S&P North American Natural Resources TR
Tactical Allocation	50% MSCI ACWI NR/ 50 % Bloomberg Barclays US Agg Bond TR USO

APPENDIX B - Investment Ranking Criteria

The criteria used to evaluate each plan investment alternative, except as otherwise noted in the Investment Policy Statement, may include, but not limited to, the following:

1. Total Return (trailing 1, 3, 5, and 10 year returns) - measures the performance of an investment over a given period, including income from dividends and interest, plus any appreciation or depreciation in the market value of the investment. Total return values longer than 1 year are typically annualized for ease of comparison.

2. Rolling Period Returns (12 month periods over 5 years) - A single period return measures performance over one specified time frame, such as five years. A rolling period return divides a longer time frame into smaller time periods. A rolling 12-month return over five years would start out by calculating a single period return over the first twelve months. Next, it would calculate the 12-month return for months 2-13. The process would continue until finally reaching the 12-month period spanning months 48-60. The final rolling 12-month return figure would reflect the average of all of the rolling periods returns over that five-year time period.

3. Rolling Period Returns (36 month periods over 10 years) - A rolling 36-month return over ten years would start out by calculating a single period return over the first thirty-six months. Next, it would calculate the 36-month return for months 2-37. The process would continue until finally reaching the 36-month period spanning months 85-120. The final rolling 36- month return figure would reflect the average of all of the rolling periods returns over that ten-year time period.

4. **Sharpe Ratio** - A risk-adjusted measure of performance that is calculated by subtracting the risk-free rate of return (the US Treasury Bill is typically used) from the portfolio return and dividing the result by the portfolio's standard deviation. A higher Sharpe ratio indicates that the portfolio was able to generate a higher return per unit of risk.

5. **Alpha** (five years) - A risk-adjusted measure of performance, that is equal to the difference between a portfolio's actual return and its expected performance given its level of risk as measured by beta. Alpha can also be viewed as an abnormal level of return in excess of what might be predicted by an equilibrium pricing model like the Capital Asset Pricing Model **{CAPM).**

6. Up **Market** Capture Ratio (five years) - A ratio that measures the overall performance of a portfolio during rising markets. This measure analyzes how well a portfolio (or an investment manager) performed relative to its benchmark index during periods when the benchmark rose. For example, an up-market

capture ratio of 108% (for a given period of time) means that the portfolio gained 8% more than its benchmark during the specified time period.

7. **Down Market Capture Ratio** (five years) - A ratio that measures the overall performance of a portfolio during falling markets. This measure analyzes how well a portfolio (or an investment manager) performed relative to its benchmark index during periods when the benchmark fell. For example, a down-market capture ratio of 95% (for a given period of time) means that the portfolio lost 5% less than its benchmark during the specified time period.

8. **R-Squared** (style consistency) - A statistical metric that ranges from zero to 100 and measures the percentage of portfolio's performance that is explained by the movement of its benchmark index. R-Squared is helpful in assessing the reliability of alpha and beta in explaining a portfolio risk and return characteristics. An r-squared of 100 would mean that the portfolio's performance movements are perfectly correlated with those of the benchmark over time and would suggest that alpha and beta may be relied upon with a high degree of confidence.

9. Expense Ratio - The percentage of investment alternative assets, net of reimbursements, used to pay for operating expenses and management fees, including 12b-1 fees, administrative fees, and all other asset-based costs incurred by the investment alternative, except brokerage costs. Investment alternative expenses are reflected in the investment alternative's NAV. Sales charges are not included in the expense ratio. The Prospectus Net Expense Ratio is collected annually from an investment alternative's prospectus.

APPENDIX C - Index Funds Ranking Criteria

The criteria used to evaluate each Index Fund alternative may include, but not limited to, the following:

1. **Expense Ratio** - The percentage of investment alternative assets, net of reimbursements, used to pay for operating expenses and management fees, including 12b-1 fees, administrative fees, and all other asset-based costs incurred by the investment alternative, except brokerage costs. Investment alternative expenses are reflected in the investment alternative 1s NAY. Sales charges are not included in the expense ratio. The Prospectus Net Expense Ratio is collected annually from an investment alternative •s prospectus.

2. Tracking Error - A measure of the difference in returns between an investment and a benchmark. Tracking error is reported as a standard deviation of the difference between the returns of an investment and its benchmark.

3. **R-Squared** - A statistical metric that ranges from zero to 100 and measures the percentage of portfolio's performance that is explained by the movement of its benchmark index. R- Squared is helpful in assessing the reliability of alpha and beta in explaining a portfolio risk and return characteristics. An r-squared of 100 would mean that the portfolio's performance movements are perfectly correlated with those of the benchmark over time and would suggest that alpha and beta may be relied upon with a high degree of confidence.

4. Beta - A measure of the volatility, or systematic risk, of an investment in comparison to a market index as a whole. Beta is calculated using regression analysis. Beta represents the tendency of an investment's returns to respond to moves in the market or index that it's calculated against. A beta of 1 indicates that the investment's price moves with the market. A beta of less than 1 means that the investment is theoretically less volatile than the market. A beta of greater than 1 indicates that the investment's price is theoretically more volatile than the market. The reliability of an investment's beta is a function of the investment's r-squared value in relation to the benchmark. A high r-squared value signifies that the beta measures is reliable, while a low r-squared signifies that it is potentially inaccurate.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

Recommend that the Board of Directors:

1. Receive Report from independent consultant Grant Thornton on employee compensation and benefits benchmarking and analysis, including Appendix: Custom Peer Groups;
2. Adopt Resolution approving updated CalOptima Policy GA.8058: Salary Schedule, with the updated Salary Schedule implemented on March 14, 2021;
3. Authorize the Chief Executive Officer to administer CalOptima compensation practices in accordance with CalOptima policies and Grant Thornton recommendations; and
4. Direct staff to research deferred compensation plan options and return to the Board with further recommendations.

Background

Near CalOptima's inception, the Board of Directors delegated authority to the CEO to develop and implement employee policies and procedures, and to amend them as appropriate from time to time, subject to annual updates to the Board, with emphasis on changes. CalOptima's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

Based on this framework, the Board has adopted Compensation Administration Guidelines that are memorialized in CalOptima Policy GA. 8057: Compensation Program. This policy specifies that CalOptima's salary structure is to be reviewed on a regular basis, either annually or every other year, to ensure that CalOptima's pay policies and practices reflect market competitiveness. The Board most recently authorized updates to CalOptima's compensation salary structure in 2015, approximately six years ago.

As part of the periodic review process spelled out in Board policy, independent compensation consultant Grant Thornton was engaged in 2018 to perform a study of CalOptima's total compensation and related compensation practices. Grant Thornton completed its review in 2019, finding that CalOptima's total compensation at all levels was below the market median as compared to geographic peer groups. While recommendations to update the salary structure and compensation practices were considered by the Board in February and March of 2020, the recommendations were not adopted at that time.

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Discussion

CalOptima does not have any labor unions or bargaining units and has not adopted automatic salary range updates or cost of living adjustments. In aggregate, wages in Southern California have increased by approximately 18.6% since 2015[1]. CalOptima's salary structure has remained at the same level during this period. The primary objective of updating CalOptima's salary structure and salary schedule is to maintain market competitiveness to attract, recruit, and retain employees, particularly in key vacant positions. Consistent with the Compensation Administration Guidelines, staff requests that the Board authorize updates to CalOptima's salary structure and salary schedule to reflect market competitiveness.

As part of its responsibilities as an independent compensation consultant, Grant Thornton evaluated CalOptima's total compensation and made a number of recommendations intended to support both CalOptima's recruitment and retention efforts. In alignment with the Board-approved Compensation Philosophy and Compensation Guidelines, the proposed salary structure reflects market data provided by Grant Thornton and an evaluation of CalOptima's operations. Since last considered by the Board at its February/March 2020 meetings, the salary structure and salary schedule recommendations have been further refined to replace the "total cash" salary ranges for Executive Director and Chief classifications with salary ranges that include "base pay" only (i.e., the incentive compensation amounts that have been included based on Grant Thornton's recommendations have been removed). This change results in lower salary ranges for these classifications. Other changes now being recommended include the addition of a separate pay grade for the classification of Medical Director. The recommended salary range for this classification is based on a 10% differential below the Deputy Chief Medical Officer's salary range, which is the next pay grade up in the salary schedule. Management recommends this change based on the difficulty in filling the existing open Medical Director positions, which are critical in meeting CalOptima's compliance and regulatory requirements and ensuring that members have access to the health care they need.

Adoption of the proposed salary structure and salary schedule will assist in recruiting not just Medical Directors, but also other hard to fill positions, and in retaining qualified employees. Management recommends implementing the Grant Thornton recommendations as follows:

- Adjust CalOptima's salary structure and salary schedule with an implementation date of March 14, 2021, as detailed in the attachments, to more closely align with current market conditions and take into account internal evaluation of job responsibilities.
- Authorize the CEO to complete a phased-in implementation of CalOptima compensation practices in accordance with recommendations by Grant Thornton in Fiscal Year (FY) 2020-21 and FY 2021-22.
- Direct staff to explore options for long-term deferred compensation to bring total compensation into alignment with the Grant Thornton recommendations and CalOptima's Board approved compensation philosophy.

[1] U.S. Bureau of Labor Statistics, *Changing Compensation Costs in the LA Metro Area;* https://www.bls.gov/regions/west/news-release/employmentcostindex_losangeles.htm

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Pursuant to California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists the Human Resources Policy that has been updated and is being presented to the Board for review and approval:

	Policy No./Name	**Summary of Changes**	**Reason for Change**
1.	GA.8058 – Salary Schedule Attachment A- Salary Schedule	• This policy addresses CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment A – Salary Schedule has been revised to reflect changes to the salary structure based on independent consultant Grant Thornton's compensation study and internal evaluation of job responsibilities. Changes include the proposed addition of new positions and the deletion of positions that are no longer in use. A summary of the changes to the Salary Schedule is included for reference. • The proposed implementation date of the Salary Schedule updates is March 14, 2021.	• Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima must update the salary schedule to reflect current job titles and pay rates for each job position. • Implementing changes to the salary schedule with an implementation date of March 14, 2021 will coincide with the start of the next pay period for ease of administration.

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Fiscal Impact

The fiscal impact of the recommended implementation of the initial phase of salary adjustments pursuant to recommendations by Grant Thornton is $1.33 million through June 30, 2021. (Note: This includes approximately $323,000 in open position adjustments.) Compensation market adjustments and unspent budgeted funds for salaries and benefits included in the FY 2020-21 Operating Budget approved by the Board on June 4, 2020, will fund the recommended actions through June 30, 2021.

The estimated annual cost for the recommended actions is approximately $4.0 million, which would result in a 2.4% increase in overall FY 2020-21 budgeted payroll expenses, or an increase of 0.1% in overall administrative expenses (based on FY 2020-21 revenues). Management plans to include updated expenses in future operating budgets.

Rationale for Recommendation

The update of CalOptima's compensation structure and program based on the recommendations of an independent compensation consultant is intended to ensure that CalOptima's compensation practices are clear, consistent, and competitive. The revised policy is intended to address the need to respond to changing market conditions and business demands for talent in a manner consistent with CalOptima's status as a public agency and the Board-approved Compensation Guidelines.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Presentation of CalOptima Salary Structure and Salary Schedule
2. Grant Thornton Compensation and Benefits Benchmarking and Analysis Report
3. Resolution No. 21-03-04, Approve Updated Human Resources Policies
4. Revised CalOptima Policy:
   a. GA. 8058: Salary Schedule (redlined and clean copies) with revised Attachment A (redlined and clean copies).
5. Summary of Changes to Salary Schedule

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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A Public Agency

CalOptima

Better. Together.

CalOptima Salary Structure and Salary Schedule

Board of Directors' Finance and Audit Committee Meeting
February 18, 2021

Brigette Hoey, Executive Director of Human Resources

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Compensation Philosophy

- The compensation program at CalOptima is intended to:
  - Attract, retain and motivate employees
  - Balance internal equity and market competitiveness to recruit and retain qualified employees
  - Instill a long-term commitment to the organization
  - Be mindful of CalOptima's status as a public agency

- Compensation program objective is to establish base salary, incentives, and benefit levels that are competitive with the median range of CalOptima's labor market, defined as:
  - Organizations of similar size and scope to CalOptima in terms of revenue, number of members, number of employees, and not-for profit status in the following industries:
    - Healthcare
    - General Industry (where applicable)
    - Other county, local and city entities

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Study Peer Groups

Government Health Care Organizations	For-Profit Health Industry Organizations	Not For Profit Health Industry Organizations
Affinity Health Plan	CNO Financial Group Inc	Blue Cross Blue Shield
Boston Medical Center Health Plan	Envision Healthcare Corp	Capital Health Plan Inc
CareOregon	Health Net Inc	Care Wisconsin Health Plan
CareSource	Healthequity Inc	Geisinger Health Plan
Commonwealth Care Alliance	Magellan Health Inc	Group Health Cooperative
Community Health Choice	Mednax Inc	Harvard Pilgrim Health Care
Driscoll Childrens Health Plan	Stancorp Financial Group Inc	HealthFirst Health Plan
ElderPlan Inc	Team Health Holdings Inc	Medica Health Plans
Inland Empire Health Plan*	Triple-S Management Corp	Tufts Associated HMO
LA Care Health Plan	Universal American Corp	
Neighborhood Health Plan Inc	Wellcare Health Plans Inc	
Virginia Premier Health Plan		

Background

- CalOptima is a non-unionized public agency
  - No Labor Unions/Bargaining Units
  - No Collective Bargaining Negotiations
- Salary Ranges Set by the Board of Directors
  - No Cost of Living Adjustments
  - No Automatic Adjustments to Salary Ranges
- Last Compensation Study was in 2013
- Current Salary Structure Adopted in March 2014
  - One Adjustment to Salary Structure Approved in 2015

Current Salary Structure

- Last updated in 2015
  - Current Minimum Wage in California for Employers with 26 Employees or More is $14 an hour or $29,120 per year
    - The yellow highlights salaries below minimum wage
  - Effective January 1, 2022, minimum wage will increase to $15 an hour or $31,200 per year.
    - The orange highlights a salary below that amount
- Compression issues within job hierarchies, limiting growth progression

Grade Level	Minimum	Midpoint	Maximum
B	$19,032	$23,816	$28,600
C	$21,008	$26,208	$31,408
D	$23,088	$28,808	$34,528
E	$25,272	$31,720	$37,960
F	$27,872	$34,840	$41,808
G	$30,576	$38,272	$45,968
H	$33,696	$42,224	$50,648
I	$37,128	$46,384	$55,640
J	$40,976	$53,352	$65,624
K	$47,112	$61,360	$75,504
L	$54,288	$70,512	$86,736
M	$62,400	$81,120	$99,840
N	$71,760	$93,184	$114,712
O	$82,576	$107,328	$131,976
P	$95,264	$128,752	$162,032
Q	$114,400	$154,440	$194,480
R	$137,280	$185,328	$233,376
S	$164,736	$222,352	$280,072
T	$197,704	$266,968	$336,024
U	$237,224	$320,216	$403,312
V	$319,740	$431,600	$543,600

CalOptima's Compensation Guidelines

- In accordance with CalOptima's Compensation Guidelines
  - Market adjustments need to be reviewed at least every 2 years and adjusted accordingly.
  - Updates based on market competitiveness evaluated based on geographic peer groups will help attract, retain, motivate, and recruit qualified employees.
- Since 2015, no changes to the Salary Structure
  - According to Bureau of Labor Statistics, Southern California wages increased on average 18.6% since 2015.
  - During same time period, CalOptima's staff doubled in size and expanded its programs without any changes to the Salary Structure
  - Over this same period, minimum wage has increased and pay structure needs to be updated to account for the increase in minimum wage and inflation.

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Grant Thornton (GT) Compensation Study Findings

- CalOptima is positioned below market median in total compensation at all levels within the organization.
- Executive and Director positions have the largest disparity to the market median, particularly with respect to annual incentives and long-term incentives.
- With the increased complexity and size, CalOptima should expect to see a significant impact in salary for employees in management positions and above to account for growth and greater responsibilities.
- While health and benefits program are generally above market, the health and benefits program does not offset the disparity in total cash compensation.

Proposed Salary Structure

- Expanded grade levels to establish more levels and ranges to alleviate compression issues within job hierarchies
- Revised salary ranges from prior proposal using data provided by Grant Thornton
  - Employees at Director and below (Letters A-T) salary ranges based on GT total cash evaluations
  - Medical Directors (Letter V) based on 10% below next level of Deputy CMO
  - Executives (Letter U-X) salary ranges based on GT market base pay with no incentives wrapped in
  - CEO (Letter Z) salary range added based on GT market base pay with no incentives wrapped in

Grade Level	Minimum	Midpoint	Maximum
A	$35,000	$40,000	$45,000
B	$37,000	$43,000	$49,000
C	$40,000	$46,000	$52,000
D	$43,000	$49,000	$55,000
E	$46,000	$53,000	$60,000
F	$50,000	$57,000	$64,000
G	$53,000	$61,000	$69,000
H	$57,000	$66,000	$75,000
I	$59,000	$71,000	$83,000
J	$63,000	$76,000	$89,000
K	$68,000	$82,000	$96,000
L	$76,000	$91,000	$106,000
M	$84,000	$101,000	$118,000
N	$93,000	$112,000	$131,000
O	$103,000	$124,000	$145,000
P	$115,000	$138,000	$161,000
Q	$127,000	$153,000	$179,000
R	$141,000	$170,000	$199,000
S	$151,000	$189,000	$227,000
T	$178,000	$222,000	$266,000
U	$209,000	$261,000	$313,000
V	$221,400	$276,300	$331,200
W	$246,000	$307,000	$368,000
X	$289,000	$361,000	$433,000
Y	N/A	N/A	N/A
Z	$400,000	$500,000	$600,000

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Recommendation

- Adopt Salary Structure and Salary Schedule
- Authorize the following adjustments for the remaining Fiscal year 2020-2021
  - ➢ Move employees who are below the proposed salary range minimum to the new range minimum, per current policy
  - ➢ Based on Grant Thornton's recommendation, qualifying employees with proven performance record of 3.0 or above, in the same level/position, with the following years of experience in that level/position at CalOptima, increase to midpoint:
    - 6-8 years for Staff
    - 5-7 years for Directors & Managers
    - 3-5 years for Executives & Chiefs
- ~~Consider for Fiscal Year 2021-2022 as part of the Budget Process~~ *Rev. 2/16/21*
  - ➢ ~~Increase the aggregate merit pool for annual performance evaluations from 3% to 5%, with increases based on proven performance~~
  - ➢ ~~Apply market adjustments per current policy, if necessary~~

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CalOptima A Public Agency

Financial Impact for FY 2020-21

Recommendations	Fiscal Year 2020-21 Impact (4 months)
Bring employees to minimum	$431,121
Bring eligible employees to midpoint based on GT methodology	$120,943
Estimated cost for open positions	$322,453
Benefits	$451,164
TOTAL	**$1,325,681**

FY 2020-21 Impact (4 months)	Executive	Medical Director	Director	Manager	Supervisor	Employee	Total
Total Staff	14	4	37	89	70	1194	**1408**
No of Staff (to Min)	1	0	10	17	16	252	**296**
No of Staff (to Mid)	5	1	2	6	3	26	**43**

* Employee count data as of 1/22/21

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CalOptima
A Public Agency

Our Mission

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

Grant Thornton

CalOptima

Compensation and Benefits Benchmarking and Analysis

May 21, 2020

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Prepared by:

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General Overview

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General Overview – About Grant Thornton

Grant Thornton LLP is the U.S. member firm of Grant Thornton International Ltd., one of the world's leading organizations of independent assurance, tax, and advisory firms. Proactive teams led by approachable partners in these firms use insights, experience and instinct to understand complex issues for not-for-profit, public sector, privately owned and publicly listed clients and help them to find solutions.

Our human capital services professionals are a senior team that possess the right mix of experience, technical skills, industry knowledge, and personal commitment to help you achieve your desired results. Not only do we know competitive benchmarking from the executive to staff level and short and long-term incentive design, but we also have the support and bench strength of national benefits and tax specialists to provide assessments on other compensation topics if needed.

We have extensive experience serving health plans similar to CalOptima. We conduct assessments of competitive compensation levels, deferred compensation and other benefits/perquisite programs using proven methodologies and relevant resources. Our ability to design and implement value-added strategies is grounded in our understanding of your business goals and value drives, as well as risk factors.

General Overview

A successful total compensation program is one that promotes the ability of an organization to recruit, retain and motivate qualified employees to help the organization achieve its mission and goals. The objective for this Compensation and Benefits Study is to assess the competitiveness of CalOptima's total compensation program, measured against similar organizations from which CalOptima competes for labor. Our review includes base salary and incentive compensation, where applicable. As well as, employee benefits that are an essential component of an employee's overall compensation such as retirement, health insurance, life insurance, pension, sick leave, vacation time, etc.

In an effort to have a program that is fair, equitable, and competitive, CalOptima has undertaken an internal review on the following key items:

- **Job descriptions.** Updated and accurate job descriptions that describe what employees are doing within their respective roles
- **Relevant markets**. Revised comparison markets by functional area and classification that more accurately captures the compensation paid at organizations from which CalOptima recruits employees
- **Market-based structure.** Salary structure that is based on a balance between defined, specific comparison markets and internal factors
- **Revised pay guidelines.** Key principles that help Human Resources administer compensation in a disciplined way to ensure that compensation of employees is managed fairly and consistently

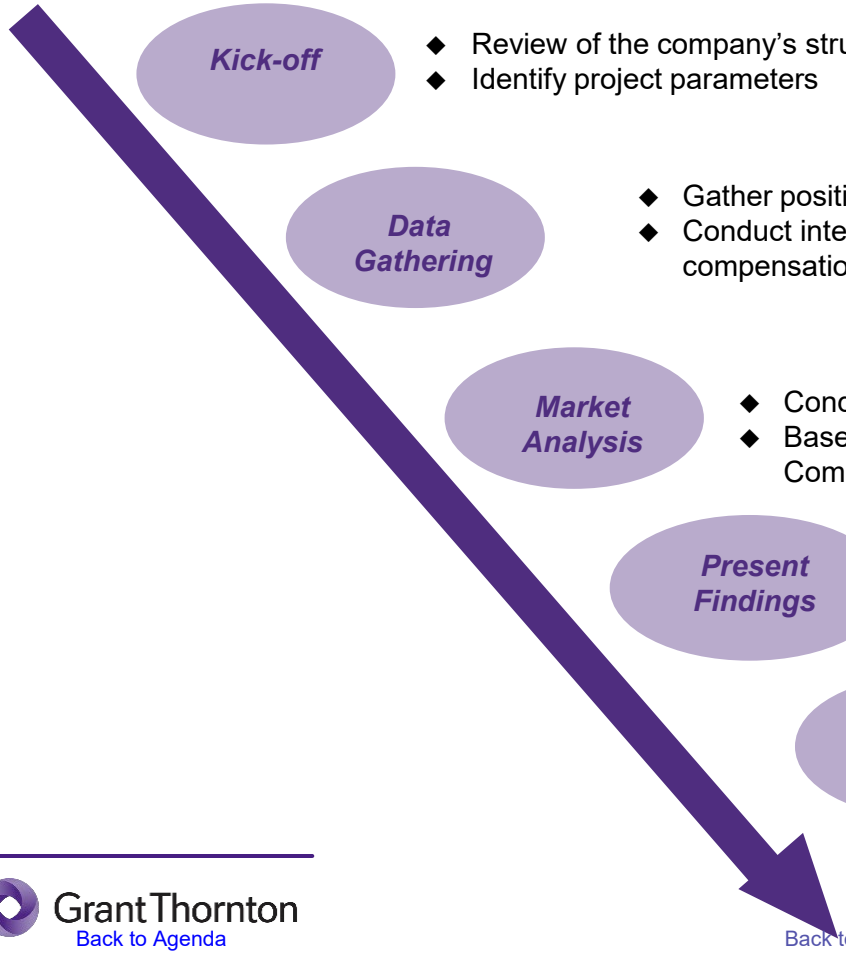
Scope of Work
Overview of Project

Grant Thornton was engaged to perform a Compensation Study (Salary and Benefits) to evaluate CalOptima's pay practices for human capital recruitment and retention as compared to other local, regional, and national organizations of similar size and operations i.e., hospitals (public agencies, non-profit and private), health plans (public agencies and private), health networks, and other employers (public agencies and private entities).

We reviewed and made recommendations on the appropriateness and competitiveness of CalOptima's current pay practices (Salary and Benefits) in order to remain competitive in the market, taking into account CalOptima's organization as a public agency and its obligation to remain fiscally prudent. We focused on skilled employees to fill and retain leadership roles and key positions essential to fulfilling the agency's strategic plan and operational goals.

The study included base pay, incentive pay, and other supplemental pay practices, along with all benefits offered to CalOptima employees (i.e. paid time off, employer share of health benefits, retirement benefits (CalPERS and PARS), life insurance, etc.) We benchmarked positions against internal CalOptima positions, where appropriate, to ensure fairness in its pay practices and to avoid pay compression. Some job titles with similar job functions and responsibilities were benchmarked against other CalOptima positions.

Scope of Work
Grant Thornton's Engagement Approach



Kick-off

- Review of the company's structure, goals, and objectives
- Identify project parameters

Data Gathering

- Gather position information, pay information, and benefit program summaries
- Conduct interviews with key stakeholders regarding issues relevant to compensation philosophy and executive pay

Market Analysis

- Conduct assessment and market comparisons:
- Base Salary, Total Cash Compensation, Total Direct Compensation, and Benefit Programs

Present Findings

- Prepare and present initial report
- Collaborate with compensation study workgroup

Next Steps

- Finalize report and any recommendations
- Implementation support as needed

Scope of Work
Peer Groups

CalOptima recruits and retains talent in the Southern California competitive job market for all positions, and broader regions - even national - for senior level management positions. Our peer groups have been customized to reflect the geographic pool for talent for these different positions.

Despite being a government agency, CalOptima competes with like health plan organizations, whether government, tax-exempt, or for-profit. Therefore, Grant Thornton (GT) conducted the competitive market analysis using a combined peer group of blended data from the following sectors of health plans on an equally blended basis:

- Government Peers
- Not-for-Profit Peers
- For-Profit Peers

Examples: An Accounts Payable Clerk was benchmarked using like positions, with equal weight on government, not-for-profit, and for-profit organizations regionally since this represents the labor pool. Alternatively, a senior executive position is benchmarked relative to the same peers, but looking at comparable organizations nationally.

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
Government Health Plan Peer Group	▪ Contains government health plan organizations of similar size and business focus to CalOptima, including LA Care and Inland Empire ▪ GT kept the same constituents of CalOptima's prior government health plan peer group (used in GT's 2017 CEO/CLO report) ▪ Used for comparison to CalOptima's executive team
Tax Exempt Health Plan Peer Group	▪ Contains tax exempt health plan organizations of similar size and business focus to CalOptima ▪ GT kept the same constituents of CalOptima's prior tax exempt health plan peer group (used in GT's 2017 CEO/CLO report) ▪ Used for comparison to CalOptima's executive team
For-Profit Health Plan Peer Group	▪ Contains for-profit health plan organizations of similar size and business focus to CalOptima ▪ GT kept the same constituents of CalOptima's prior public health plan peer group (used in GT's 2017 CEO/CLO report) ▪ Used for comparison to CalOptima's executive team

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
ERI	▪ Economic Research Institute ("ERI") is a nationally recognized for profit regression based survey ▪ We have pulled compensation data for the "Medical, Dental, & Disability Plans" sector for organizations with $700M in assets ▪ Used for comparison to CalOptima's executive team, directors, managers, and staff level positions
Health Plan Survey	▪ Lastly, we have used a confidential health plan survey that has compensation information for executives, directors, managers, and staff in tax exempt and public health plans. ▪ Used for comparison to CalOptima's executive team, directors, managers, and staff level positions

Executive Summary

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Executive Summary
Current Total Rewards Environment

CalOptima reviewed their total rewards program in 2013. To provide context on the current market, we highlighted the following total rewards trends for the last five years:

- Salaries
  - 3% to 4% annual salary increase in market, totaling an average market movement of 15% to 20% over the last five years
- Annual Incentives
  - Almost universal use of incentives in the health plan market, across all ownership types, with payouts often averaging above target or expected levels
- Long-Term Incentives
  - Universal use with for-profit health plans, and majority practice for large health plans
- Total Compensation (Inclusive of Benefits)
  - Increases at a rate consistent with salaries, since benefits and incentive values are typically expressed/provided as a percent of salary
  - Generally, benefit cost increases are shared partially employees/participants
- The market's total compensation increases are above the standard levels described above for growing job levels, considering that market total compensation increases by 5% to 20% for every doubling in organizational size (e.g., $3B health plan pay levels would tend to be 5% to 20% higher then $1.5B health plan)
  - Leadership position pay values are more sensitive to organizational size than staff levels
- The current labor market is an employees market due to the historically low unemployment rate

Executive Summary
Compensation Program

- Base Salary
  - On average:
    - Executives are positioned 13% below market median
    - Directors are positioned 13% below market median
    - Managers are positioned 6% below market median
    - Staff are positioned 4% below market median
- Total Cash Compensation (Base Salary + Annual Incentives)
  - On average:
    - Executives are positioned 30% below market median
    - Directors are positioned 24% below market median
    - Managers are positioned 13% below market median
    - Staff are positioned 7% below market median
    - Disparities are due to the limited incentive compensation offered
- Total Direct Compensation (Base Salary + Annual Incentives + Long-Term Incentives)
  - On average, executives are positioned 43% below market median
  - Disparity is due to the lack of a long-term incentive plan at CalOptima

Executive Summary
Compensation Program

- While we used a blend of data from government, tax exempt, and for-profit health plans in our study, we wanted to show how CalOptima pay compares against only government health plan pay data.
- We looked at the median market base salaries of 5 executives, 5 managers, and 5 staff positions to see how the government data compared against the blended data and CalOptima's midpoints. The charts below and on the next slide outline our findings:

Base Salary				
Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$320,216	$397,000	$351,640	-11%
Chief Operating Officer	$320,216	$335,000	$284,380	-15%
Chief Medical Officer	$320,216	$380,000	$374,060	-2%
Chief Information Officer	$266,968	$299,000	$260,000	-13%
Chief Counsel	$266,968	$343,000	$293,800	-14%
			Average	**-11%**

Total Cash				
Title	CalOptima Total Cash Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$520,000	$393,900	-24%
Chief Operating Officer	$352,238	$444,000	$318,500	-28%
Chief Medical Officer	$352,238	$453,000	$421,260	-7%
Chief Information Officer	$293,665	$370,000	$262,600	-29%
Chief Counsel	$293,665	$494,000	$382,200	-23%
			Average	**-22%**

Total Direct				
Title	CalOptima Total Direct Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$663,000	$439,400	-34%
Chief Operating Officer	$352,238	$480,000	$352,300	-27%
Chief Medical Officer	$352,238	$619,000	$456,660	-26%
Chief Information Officer	$293,665	$392,000	$330,200	-16%
Chief Counsel	$293,665	$500,000	$442,500	-12%
			Average	**-23%**

- On average, the government peer group data is 11% lower than the blended peer group data for executive base salaries.
- On average, the government peer group data is 22% lower than the blended peer group data for executive total cash compensation.
- On average, the government peer group data is 23% lower than the blended peer group data for executive total direct compensation.

Executive Summary
Compensation Program

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Manager Accounting	$93,184	$120,000	$119,800	0%
Manager Communications	$93,184	$100,000	$95,000	-5%
Manager Customer Service	$93,184	$85,000	$83,500	-2%
Manager Facilities	$93,184	$89,000	$82,200	-8%
Manager Finance	$93,184	$117,000	$114,000	-3%
			Average	**-3%**

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Actuary	$107,328	$126,000	$110,000	-13%
Accountant Intermediate	$70,512	$73,000	$70,000	-4%
Accounting Clerk	$46,384	$42,000	$45,000	7%
Payroll Specialist	$53,352	$53,000	$52,000	-2%
Buyer Intermediate	$61,360	$69,000	$65,000	-6%
			Average	**-3%**

- On average, the government peer group data is 3% lower than the blended peer group data for manager and staff base salaries.
- While government health plans tend to have lower pay levels, it is important to consider organizational size and complexity when analyzing pay levels. Due to CalOptima's expansion of programs and members, which has resulted in increased complexity and more than doubling in size since 2014, we looked at data for labor markets for bigger organizations, including a blend of government, tax exempt, and for-profit health plans, comparable in size and revenue, in our analysis.
- With the increased complexity and size, CalOptima should expect to see a significant impact in salary for employees in management positions and above to account for growth and greater responsibilities.

Executive Summary
Benefits Program

- Health and Welfare Programs
  - Offering four medical plans allow employees more choice and flexibility
  - The health plans offered by CalOptima offer a high level of benefits
  - HMO plans have much lower employee contributions and slightly better cost-sharing than market
  - HDHP and PPO plans have average employee contributions and cost-sharing compared to market
  - Prescription drug, dental, vision, life, LTD, and STD benefits are competitive or above market
- Retirement Programs
  - Participants receive employer contributions in both the defined contribution (PARS) and a defined benefit plan (CalPERS)
- Vacation/Paid Time-Off Programs
  - Offers more time-off than the composite benchmark, but less than other public agencies

This analysis was based on composite benchmarks of organizations of similar size, geography, and industry

Executive Summary
Benefits Program

- CalOptima is above market from a total benefits program perspective
- Time-off programs are above market but less than other public agencies
- The strongest benefit is the CalPERS defined benefit plan, though CalOptima adopted one of the lowest benefit formulas as compared to other public agency peers

Market Competitiveness*	
Retirement Benefits	Above Market
Medical Benefits	Above Market
Dental Benefits	Above Market
Vision Benefits	At Market
Disability Benefits	At Market
Life Insurance Benefits	At Market
Time-Off Programs	Above Market
Total Benefits Program	**Above Market**

* This analysis was based on composite benchmarks of organizations of similar size, geography, and industry.

Executive Summary
Total Compensation

- By group, with compensation generally being below median and benefits being above median, average total compensation is as follows:
  - Executives and Directors are well below median
    - Driven primarily by aggressive incentive practices in peers
    - Compensation gap is not closed by above market benefits
  - Managers are moderately below median
    - Compensation gap is moderated based on above market benefits
  - Staff are positioned close to median
    - Compensation gap is made up due to highly competitive benefits

Recommendations

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Compensation Recommendations
Total Compensation Philosophy

The following are principles that can be used as the foundation of CalOptima's total compensation program:

- To reinforce the mission of the organization
- To achieve balance between the needs and concerns of CalOptima employees, and the communities it serves
- To attract and retain outstanding employees
- To motivate and reward outstanding performance
- To link compensation to consistent merit principles, including both individual and organizational performance
- To base decisions on appropriate comparability data provided by independent sources
- To ensure that compensation and benefits programs comply with all pertinent laws and regulations
- To maintain consistency and fairness, to the extent possible, without violating other principles
- To provide benefits in a manner that allows employees to participate in determining how best to meet their needs and those of their families

Compensation Recommendations
Total Rewards Competitive Positioning

- CalOptima wishes to recruit, retain, and motivate staff in order to accomplish organizational mission, vison, and strategic objectives. With this goal in mind, CalOptima intends to provide a total compensation program that is competitive with organizations that represent the competitive labor market for CalOptima's various staff positions.
- To achieve competitiveness, total compensation will be positioned at the:
  - 50th percentile for executives
  - 50th percentile for directors and managers
  - 50th percentile for most staff positions
  - Approximately the 62.5 percentile (between the 50th and 75th) for hard to fill staff positions, i.e. nursing, legal, and accounting staff.
- Base salaries, limited incentives and recognition and rewards, targeted at market median.
- Benefits targeted above market median.
- Pay for performance provides flexibility to position pay 10% to 20% above market for sustained outstanding performance.

Compensation Recommendations

Overall, CalOptima compensation is positioned below market, with the executives and directors most significantly lagging the market due to a combination of low salaries and low or no incentives. Our conceptual considerations are as follows:

- Base Salary
  - Implement CalOptima's compensation philosophy with market-based salary ranges, with market adjustments for those that are below market positioning and that have performed at a "meets expectations" level for a period of years.
  - With benefits above market, target base salary as follows:
    - 10% below 50th percentile total cash executives
    - 50th percentile total cash for directors and managers
    - 50th percentile total cash for most staff
    - For hard to recruit positions, we recommend positioning between the 50th and 75th percentile (62.5 percentile)

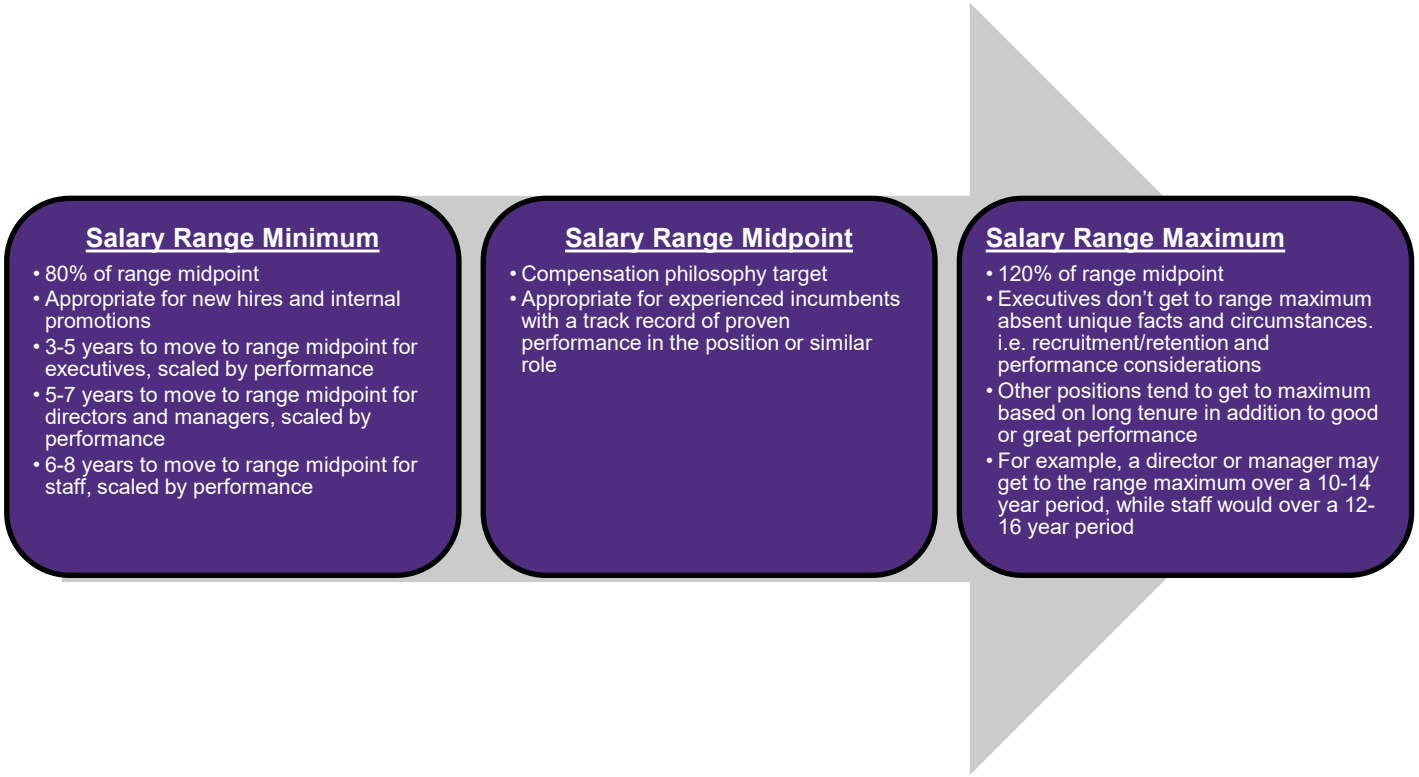
Compensation Recommendations

- Annual Incentive Compensation
  - Maintain existing annual incentive plan structure, with 10% target incentives, which would position target pay at the 50th percentile total cash
  - However, potentially add Directors and Managers to the annual incentive plan over the next two years

- Other Incentives
  - No additional incentives, for the time being, given the administrative difficulty on introducing higher incentives, either on an annual or long-term incentive basis

Compensation Recommendations
Base Salary Administration Guidelines

- The following is an example of competitive salary administration guidelines to help manage salaries around market-based compensation philosophy



Compensation Recommendations

- Adjustments for FY 2019-20:
  - Move employees who are below proposed salary range minimum to the minimum (as required by CalPERS reporting)
  - Move employees with a track record of proven performance in the same level or position at CalOptima to midpoint based on methodology identified on the previous slide

- Ongoing for FY 2020-21:
  - Increase the aggregate merit pool from 3% to 5%
  - Apply market adjustments per current policy if necessary

- ***Methodology will deal with internal equity and compression issues inherently within each job, and amongst like jobs***

Other Compensation Recommendations

- Upon implementation of 50th percentile total cash salary ranges, total compensation will still lag market for the executives and some directors
- We would suggest addressing a portion of this gap by implementing a non-qualified deferred compensation plan for executives and other select leadership positions, structured either as
  - A mid-term retention plan, whereby anywhere from 5% to 20% of salary is set aside per year, subject to a three to five year cliff vest (i.e., the dollars set aside are only earned and paid out to the extent the leader is employed by the organization at the end of the vesting period, or
  - Supplemental executive retirement plan, whereby a certain amount is set aside at the same value as the qualified retirement plan for those earnings above and beyond the qualified plan limits (i.e., restoration plan)
- The above strategy would still result in leadership pay being below market – but would assist in having incentives to retain key talent

Recommended Salary Structure

Grade Level	Minimum	Midpoint	Maximum
X	$ 347,000	$ 434,000	$ 521,000
W	$ 295,000	$ 369,000	$ 443,000
V	$ 251,000	$ 314,000	$ 377,000
U	$ 214,000	$ 267,000	$ 320,000
T	$ 182,000	$ 227,000	$ 272,000
S	$ 154,000	$ 193,000	$ 232,000
R	$ 144,000	$ 174,000	$ 204,000
Q	$ 130,000	$ 157,000	$ 184,000
P	$ 117,000	$ 141,000	$ 165,000
O	$ 105,000	$ 127,000	$ 149,000
N	$ 95,000	$ 114,000	$ 133,000
M	$ 85,000	$ 103,000	$ 121,000

Grade Level	Minimum	Midpoint	Maximum
L	$ 77,000	$ 93,000	$ 109,000
K	$ 70,000	$ 84,000	$ 98,000
J	$ 65,000	$ 78,000	$ 91,000
I	$ 61,000	$ 73,000	$ 85,000
H	$ 59,000	$ 68,000	$ 77,000
G	$ 55,000	$ 63,000	$ 71,000
F	$ 51,000	$ 59,000	$ 67,000
E	$ 48,000	$ 55,000	$ 62,000
D	$ 44,000	$ 51,000	$ 58,000
C	$ 41,000	$ 47,000	$ 53,000
B	$ 38,000	$ 44,000	$ 50,000
A	$ 36,000	$ 41,000	$ 46,000

*Please note that recommendation for CEO pay range is not included as part of this study

Benefits Recommendations
General Overview

- Annual Strategic Analysis
  - Develop a formalized annual review process to review the goals and strategies of CalOptima's benefits program
    - Develop broad strategies and goals for CalOptima's compensation and benefits programs
    - Develop the general framework of the programs and how they will support the needs of employees and the financial constraints
    - Determine the employee's value of the benefit offerings versus the cost and, if appropriate, shift resources to items that employees value
  - Prepare a written benefit program philosophy that can create guiding principles to make benefit program decisions such as plan design changes. (For example, employees should pay low medical premiums, but have higher cost sharing.)
- Financial Modeling and Projections
  - Analyze the relative costing information for each alternative to understand financial implications of the benefit program decisions
  - Analyze advantages and disadvantages of each alternative, including the financial implications, and document them
  - Prepare a cost/benefit analysis to assess the benefits as well as the employer and employee costs. (For example, reinstituting the employer HSA contributions can increase participant enrollment and save both the employee and employer money.)

Benefits Recommendations
Program Issues

Overall, CalOptima benefits are positioned above market. The benefits recommendations below would not significantly change CalOptima's position in the market.

- Medical/Health Insurance
  - CalOptima offers medical plans with above market benefit levels and high employer cost share. CalOptima should consider reviewing its benefit strategy in order to reduce total plan costs, such as
    - Plan designs changes to encourage in-network utilization
    - Promote participant consumerism and cost-effective decisions
- Prescription Drug Programs
  - Consider pharmacy cost-saving measures, such as:
    - Excluding certain drugs with lower cost alternatives
    - Encouraging participation in the mail-order program
    - Implementing step-therapy for certain high-cost drugs
- Life and Disability Insurance Programs
  - Consider increasing the basic life insurance maximum to $500,000 to give an increased benefit to highly paid employees
  - Consider a cost/benefit analysis to join the California Short-Term Disability Insurance
- Retirement Programs
  - Consider consolidating the 457(b) Plan and 401(a) PARS Plan to a single vendor in order to reduce administrative and investment fees that will benefit participants by increasing their investment returns

Appendix
Custom Peer Groups – Government Peer Group (like CalOptima)

Government Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
Affinity Health Plan	Health-General & Financing	$1,418,105,612	$376,092,562
Boston Medical Center Health Plan	Health-General & Financing	$1,640,398,973	$429,520,379
CareOregon	Health-General & Financing	$971,484,613	$425,539,455
CareSource	Health-General & Financing	$6,531,587,542	$1,831,803,361
Commonwealth Care Alliance	Health-General & Financing	$809,417,329	$175,417,209
Community Health Choice	Health-General & Financing	$851,462,290	$239,892,454
Driscoll Childrens Health Plan	Health-General & Financing	$438,714,445	$83,473,281
ElderPlan Inc	Health-General & Financing	$904,056,324	$199,305,781
Inland Empire Health Plan*	Health-General & Financing	$4,302,922,597	$1,782,242,790
LA Care Health Plan	Health-General & Financing	$8,304,109,805	$459,986,900
Neighborhood Health Plan Inc	Health-General & Financing	$2,536,658,776	$456,299,895
Virginia Premier Health Plan	Health-General & Financing	$1,063,725,747	$386,298,189

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$438,714,445	$83,473,281
25th Percentile	$890,907,816	$229,745,786
Average	$2,481,053,671	$570,489,355
Median	$1,240,915,680	$405,918,822
75th Percentile	$2,978,224,731	$457,221,646
90th Percentile	$6,308,721,048	$1,650,017,201
Maximum	$8,304,109,805	$1,831,803,361

Appendix
Custom Peer Groups – NFP Peer Group

NFP Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
Blue Cross Blue Shield	Health-General & Financing	$512,533,419	$650,271,510
Capital Health Plan Inc	Health-General & Financing	$939,178,501	$480,125,384
Care Wisconsin Health Plan	Health-General & Financing	$123,315,773	$34,840,468
Geisinger Health Plan	Health-General & Financing	$2,109,272,521	$535,769,375
Group Health Cooperative	Health-General & Financing	$416,836,322	$119,242,329
Harvard Pilgrim Health Care	Health-General & Financing	$1,979,581,176	$958,882,498
HealthFirst Health Plan	Health-General & Financing	$2,028,384,559	$652,104,450
Medica Health Plans	Health-General & Financing	$2,108,568,644	$896,765,075
Tufts Associated HMO	Health-General & Financing	$2,995,230	$1,126,552,016

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CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$2,995,230	$34,840,468
25th Percentile	$416,836,322	$480,125,384
Average	$1,135,629,572	$606,061,456
Median	$939,178,501	$650,271,510
75th Percentile	$2,028,384,559	$896,765,075
90th Percentile	$2,108,709,419	$992,416,402
Maximum	$2,109,272,521	$1,126,552,016

Appendix
Custom Peer Groups – For-Profit Peer Group

For-Profit Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
CNO Financial Group Inc	Life & Health Insurance	$3,992,400,000	$31,975,200,000
Envision Healthcare Corp	Health Care Services	$3,696,000,000	$16,708,900,000
Health Net Inc	Managed Health Care	$16,243,587,000	$6,397,646,000
Healthequity Inc	Managed Health Care	$178,370,000	$279,136,000
Magellan Health Inc	Managed Health Care	$4,836,884,000	$2,443,687,000
Mednax Inc	Health Care Services	$3,183,159,000	$5,339,400,000
Stancorp Financial Group Inc	Life & Health Insurance	$2,902,400,000	$23,174,400,000
Team Health Holdings Inc	Health Care Services	$3,597,247,000	$4,060,842,000
Triple-S Management Corp	Managed Health Care	$2,984,806,000	$2,218,999,000
Universal American Corp	Managed Health Care	$1,379,646,000	$785,583,000
Wellcare Health Plans Inc	Managed Health Care	$14,237,100,000	$6,152,800,000

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CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$178,370,000	$279,136,000
25th Percentile	$2,943,603,000	$2,331,343,000
Average	$5,202,872,636	$9,048,781,182
Median	$3,597,247,000	$5,339,400,000
75th Percentile	$4,414,642,000	$11,553,273,000
90th Percentile	$14,237,100,000	$23,174,400,000
Maximum	$16,243,587,000	$31,975,200,000

Disclosure

Our review was limited to the documents provided by CalOptima and did not include the underlying plan documents and summary plan descriptions. Our findings were based on the documents provided including employment agreements, policies, and summaries.

Our conclusions relate only to our understanding of the facts provided by CalOptima which are stated in this analysis. We have not independently verified these facts, and if any of these facts prove to be in error, the conclusions reached in this memorandum do not apply. Our conclusions are based on the Department of Labor, Internal Revenue Code, regulations and interpretations thereunder in their form as of the date of this analysis. We are under no obligation to update our conclusions for future changes in these authorities. Our conclusions are based on our interpretation of the tax law. Another party, such as the Internal Revenue Service or a court, hearing the same facts may reach different conclusions.

In accordance with applicable professional regulations, please understand that, unless expressly stated otherwise, any written advice contained in, forwarded with, or attached to this document is not intended or written by Grant Thornton LLP to be used, and cannot be used, by any person for the purpose of avoiding any penalties that may be imposed under the Internal Revenue Code.

RESOLUTION NO. 21-0304-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED HUMAN RESOURCES POLICY

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy:

a. GA.8058 Salary Schedule with Attachment A to be implemented March 14, 2021

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this March 4, 2021.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

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

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Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	03/04/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

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8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 03/04/2021)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
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03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative

1

GLOSSARY

Not Applicable

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	05/01/2014
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II. POLICY

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1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

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8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 03/04/2021)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative

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GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021

To be Implemented March 14, 2021

Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	H	39	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Accountant Int	I	634	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Accountant Sr	K	68	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Accounting Clerk	D	334	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Actuary	O	357	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Administrative Assistant	D	19	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Analyst	H	562	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Analyst Int	I	563	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Analyst Sr	J	564	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Applications Analyst	I	232	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Applications Analyst Int	J	233	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Assistant~~ Associate Director	P	682	$117,000	$141,000	$165,000	Revised Job Title and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000	New Position
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Associate Director Provider Network~~	~~O~~	~~647~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Auditor	I	565	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Auditor Sr	J	566	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Board Services Specialist	E	435	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Business Analyst	J	40	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Buyer	G	29	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Buyer Int	H	49	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Buyer Sr	I	67	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Care Manager	K	657	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Certified Coder	H	399	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Change Control Administrator	I	499	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Change Management Analyst Sr~~	~~N~~	~~465~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Chief Counsel	X	132	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Financial Officer	X	134	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Information Officer	W	131	$246,000	$307,000	$368,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021

To be Implemented March 14, 2021

Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Chief Medical Officer	X	137	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Operating Officer	X	136	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims - Lead	G	574	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims Examiner	C	9	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clerk of the Board	O	59	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Auditor	L	567	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Communications Specialist	G	188	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Community Partner	G	575	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Community Partner Sr	H	612	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Community Relations Specialist	G	288	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contract Administrator	K	385	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contracts Manager	M	207	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Contracts Specialist	I	257	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Controller	T	464	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Rep	C	5	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Data Analyst	J	337	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Data Analyst Int	K	341	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Data Analyst Sr	L	342	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Entry Tech	A	3	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021

To be Implemented March 14, 2021

Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
**	~~Data Warehouse Project Manager~~	~~O~~	~~362~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator	L	90	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Clerk of the Board	K	~~684~~	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Accounting~~	~~P~~	~~122~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Applications Management~~	~~R~~	~~170~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Business Development~~	~~P~~	~~351~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	~~Director Business Integration~~	~~Q~~	~~543~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
*	Director Case Management	S	318	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Claims Administration	R	112	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Clinical Outcomes~~	~~Q~~	~~602~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Director Communications	R	361	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Director Community Relations~~	~~P~~	~~292~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	~~Director Configuration & Coding~~	~~Q~~	~~596~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
	Director Contracting	R	184	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director COREC~~	~~Q~~	~~369~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
	Director Customer Service	R	118	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	~~Director Electronic Business~~	~~P~~	~~358~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Facilities	Q	428	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Finance & Procurement~~	~~P~~	~~157~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Director Financial Analysis	T	374	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Financial Compliance	R	460	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Director Health Services~~	~~Q~~	~~328~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
*	Director Human Resources	S	322	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Information Services	T	547	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Medi-Cal Plan Operations~~	~~P~~	~~370~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Director Network Management	R	125	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director OneCare Operations~~	~~P~~	~~425~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	~~Director Organizational Training & Education~~	~~P~~	~~579~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Director PACE Program	S	449	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Population Health Management	Q	675	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Process Excellence	R	447	$144,000	$174,000	$204,000	Revised Job Title and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Program Implementation	R	489	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Project Management~~	~~Q~~	~~447~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position

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	Director Provider Data Quality	Q	655	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Provider Services~~	~~P~~	~~597~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	~~Director Public Policy~~	~~P~~	~~459~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000	New Position
	~~Director Quality (LTSS)~~	~~Q~~	~~613~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
	Director Quality Analytics	R	591	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Quality Improvement	R	172	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Strategic Development	R	121	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Director Systems Development~~	~~R~~	~~169~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Vendor Management	Q	685	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Disease Management Coordinator~~	~~M~~	~~70~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~Disease Management Coordinator - Lead~~	~~M~~	~~472~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~EDI Project Manager~~	~~O~~	~~403~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Executive Assistant	G	339	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Compliance	U	493	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Human Resources	U	494	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Network Operations	U	632	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Executive Director Operations	U	276	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director, Behavioral Health Integration	U	614	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000	New Position
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Analyst	J	51	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Gerontology Resource Coordinator~~	~~M~~	~~204~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Graphic Designer	K	387	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Coach	K	556	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Educator	H	47	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Educator Sr	I	355	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021

To be Implemented March 14, 2021

Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~HEDIS Case Manager (LVN)~~	~~M~~	~~552~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Help Desk Technician	E	571	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Assistant	D	181	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Business Partner	M	584	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~HR Compensation Specialist Sr~~	~~N~~	~~663~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
*	HR Coordinator	F	316	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~*~~	HR Representative	J	278	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Representative Sr	L	350	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Specialist	G	505	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~HRIS Analyst Sr~~	~~M~~	~~468~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~ICD-10 Project Manager~~	~~O~~	~~411~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~*~~	Intern	A	237	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Investigator Sr	I	553	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	IS Coordinator	E	365	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Manager	N	424	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Specialist	K	549	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Kitchen Assistant	A	585	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Legislative Program Manager~~	~~N~~	~~330~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Litigation Support Specialist	K	588	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	LVN (PACE)	K	533	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	LVN Specialist	K	686	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Mailroom Clerk	A	1	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Accounting	O	98	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Actuary	Q	453	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Manager Applications Management~~	~~P~~	~~271~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Behavioral Health	O	633	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Business Integration	O	544	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Manager Case Management	P	270	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Claims	O	92	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Clinic Operations	N	551	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~*~~	Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Coding Quality	N	382	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Communications	N	398	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Community Relations	N	384	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Manager Contracting	O	329	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Creative Branding	M	430	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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To be Implemented March 14, 2021

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	Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Customer Service	M	94	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Decision Support~~	~~O~~	~~454~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Manager Electronic Business	N	422	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Employment Services~~	~~N~~	~~420~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Manager Encounters	M	516	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Facilities~~	~~N~~	~~209~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Manager Finance	O	148	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Financial Analysis	P	356	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Government Affairs	N	437	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Health Education~~	~~N~~	~~173~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	~~Manager HEDIS~~	~~O~~	~~427~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Manager Human Resources	O	526	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Information Services	P	560	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Information Technology~~	~~P~~	~~110~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	~~Manager Integration Government Liaison~~	~~N~~	~~455~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Medical Data Management~~	~~O~~	~~519~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	~~Manager Medi-Cal Program Operations~~	~~N~~	~~483~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Member Outreach Education & Provider Relations~~	~~O~~	~~576~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Manager MSSP	O	393	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager OneCare Regulatory~~	~~N~~	~~197~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
*	~~Manager OneCare Sales~~	~~O~~	~~248~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager PACE Center	N	432	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Population Health Management	N	674	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Process Excellence	O	622	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Program Implementation	N	488	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Project Management~~	~~O~~	~~532~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Provider Network	O	191	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Manager Provider Services~~	~~O~~	~~656~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
*	Manager Purchasing	O	275	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	~~Manager Strategic Operations~~	~~N~~	~~446~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	~~Manager Systems Development~~	~~P~~	~~515~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	Manager Utilization Management	P	250	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Assistant	C	535	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Case Manager	L	72	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Medical Director	V	306	$221,400	$276,300	$331,200	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Occupational Therapist	L	531	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Office Clerk	A	335	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Outreach Specialist	C	218	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Payroll Specialist	E	554	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Performance Analyst	I	538	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Physical Therapist	L	530	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Privacy Manager	N	536	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Privacy Officer	O	648	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Process Excellence Manager	N	529	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Assistant	C	24	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Program Coordinator	C	284	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Manager	L	421	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Manager Sr	M	594	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Specialist	E	36	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Specialist Int	G	61	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Specialist Sr	I	508	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program/Policy Analyst	I	56	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Programmer	K	43	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Programmer Int	M	74	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Programmer Sr	N	80	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Project Manager	L	81	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Project Manager - Lead	M	467	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Project Manager Sr	N	105	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Project Specialist	E	291	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Project Specialist Sr	I	503	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Projects Analyst	G	254	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Enrollment Data Coordinator	D	12	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Enrollment Data Coordinator Sr	F	586	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Specialist	H	44	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~*~~	Provider Office Education Manager	I	300	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Relations Rep	G	205	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Publications Coordinator	G	293	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QA Analyst	I	486	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QA Analyst Sr	L	380	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	QI Nurse Specialist	M	82	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Receptionist	B	140	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Records Manager	Q	TBD	$130,000	$157,000	$184,000	New Position
	Recreational Therapist	H	487	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Recruiter~~	~~L~~	~~406~~	~~$54,288~~	~~$70,512~~	~~$86,736~~	Remove Position
	~~Recruiter Sr~~	~~M~~	~~497~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Registered Dietitian	I	57	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	RN (PACE)	M	480	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Analyst Int	M	534	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Security Officer	B	311	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021

To be Implemented March 14, 2021

Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Social Worker	J	463	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker Sr	K	690	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Special Counsel	T	317	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Sr Director Regulatory Affairs and Compliance~~	~~R~~	~~658~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Sr Manager Government Affairs~~	~~O~~	~~451~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Sr Manager Provider Network~~	~~O~~	~~651~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Staff Attorney	P	195	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Supervisor Claims	I	219	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Supervisor Encounters	I	253	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Finance	M	419	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Supervisor Health Education~~	~~M~~	~~381~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Provider ~~Enrollment~~ Data Management Services	K	439	$70,000	$84,000	$98,000	Revised job title and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Supervisor Systems Development~~	~~O~~	~~456~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Systems Manager~~	~~N~~	~~512~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Technical Analyst Int	J	64	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Technical Analyst Sr	L	75	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Technical Writer	H	247	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Technical Writer Sr	J	470	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Therapy Aide	E	521	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Training Administrator	I	621	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Training Program Coordinator	H	471	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Translation Specialist	B	241	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Web Architect	N	366	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 03/04/2021

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	H	39	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Accountant Int	I	634	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Accountant Sr	K	68	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Accounting Clerk	D	334	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Actuary	O	357	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Administrative Assistant	D	19	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Analyst	H	562	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Analyst Int	I	563	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Analyst Sr	J	564	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Applications Analyst	I	232	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Applications Analyst Int	J	233	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Associate Director	P	682	$117,000	$141,000	$165,000	Revised Job Title and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000	New Position
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Auditor	I	565	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Auditor Sr	J	566	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Board Services Specialist	E	435	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Business Analyst	J	40	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Buyer	G	29	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Buyer Int	H	49	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Buyer Sr	I	67	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Care Manager	K	657	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Certified Coder	H	399	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Change Control Administrator	I	499	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Counsel	X	132	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Financial Officer	X	134	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Information Officer	W	131	$246,000	$307,000	$368,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Chief Medical Officer	X	137	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Chief Operating Officer	X	136	$289,000	$361,000	$433,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims - Lead	G	574	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims Examiner	C	9	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clerk of the Board	O	59	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Auditor	L	567	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Communications Specialist	G	188	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Community Partner	G	575	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Community Partner Sr	H	612	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Community Relations Specialist	G	288	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contract Administrator	K	385	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contracts Manager	M	207	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	Contracts Specialist	I	257	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Controller	T	464	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Rep	C	5	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Data Analyst	J	337	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Data Analyst Int	K	341	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Data Analyst Sr	L	342	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Entry Tech	A	3	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator	L	90	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Case Management	S	318	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Claims Administration	R	112	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Director Communications	R	361	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Contracting	R	184	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Customer Service	R	118	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Facilities	Q	428	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Financial Analysis	T	374	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Financial Compliance	R	460	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Human Resources	S	322	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Information Services	T	547	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Network Management	R	125	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director PACE Program	S	449	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Population Health Management	Q	675	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Process Excellence	R	447	$144,000	$174,000	$204,000	Revised Job Title and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Program Implementation	R	489	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Provider Data Quality	Q	655	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000	New Position
	Director Quality Analytics	R	591	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Quality Improvement	R	172	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Strategic Development	R	121	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Director Vendor Management	Q	685	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Executive Assistant	G	339	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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To be Implemented March 14, 2021
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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Compliance	U	493	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Human Resources	U	494	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Network Operations	U	632	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Executive Director Operations	U	276	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Director, Behavioral Health Integration	U	614	$209,000	$261,000	$313,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000	New Position
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Analyst	J	51	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Graphic Designer	K	387	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Coach	K	556	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Educator	H	47	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Educator Sr	I	355	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Help Desk Technician	E	571	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Assistant	D	181	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Business Partner	M	584	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	HR Coordinator	F	316	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	HR Representative	J	278	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Representative Sr	L	350	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Specialist	G	505	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	Intern	A	237	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Investigator Sr	I	553	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	IS Coordinator	E	365	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Manager	N	424	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Specialist	K	549	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Kitchen Assistant	A	585	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Litigation Support Specialist	K	588	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	LVN (PACE)	K	533	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	LVN Specialist	K	686	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Mailroom Clerk	A	1	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Accounting	O	98	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Actuary	Q	453	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Behavioral Health	O	633	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Business Integration	O	544	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Manager Case Management	P	270	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Claims	O	92	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Clinic Operations	N	551	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
±	Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Coding Quality	N	382	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Communications	N	398	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Community Relations	N	384	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Manager Contracting	O	329	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Creative Branding	M	430	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Customer Service	M	94	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Electronic Business	N	422	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Encounters	M	516	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Finance	O	148	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Financial Analysis	P	356	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Government Affairs	N	437	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Human Resources	O	526	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Information Services	P	560	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager MSSP	O	393	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager PACE Center	N	432	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Manager Population Health Management	N	674	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Process Excellence	O	622	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Program Implementation	N	488	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Provider Network	O	191	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Manager Purchasing	O	275	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Manager Utilization Management	P	250	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Assistant	C	535	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Case Manager	L	72	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Medical Director	V	306	$221,400	$276,300	$331,200	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Occupational Therapist	L	531	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Office Clerk	A	335	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Outreach Specialist	C	218	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Payroll Specialist	E	554	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Performance Analyst	I	538	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Physical Therapist	L	530	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Privacy Manager	N	536	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Privacy Officer	O	648	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Process Excellence Manager	N	529	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Assistant	C	24	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Program Coordinator	C	284	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Manager	L	421	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Manager Sr	M	594	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Specialist	E	36	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Specialist Int	G	61	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program Specialist Sr	I	508	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Program/Policy Analyst	I	56	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Programmer	K	43	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Programmer Int	M	74	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Programmer Sr	N	80	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Project Manager	L	81	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Project Manager - Lead	M	467	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Project Manager Sr	N	105	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Project Specialist	E	291	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Project Specialist Sr	I	503	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Projects Analyst	G	254	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Enrollment Data Coordinator	D	12	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Enrollment Data Coordinator Sr	F	586	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Specialist	H	44	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Provider Office Education Manager	I	300	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Relations Rep	G	205	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Publications Coordinator	G	293	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QA Analyst	I	486	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QA Analyst Sr	L	380	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	QI Nurse Specialist	M	82	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Receptionist	B	140	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Records Manager	Q	TBD	$130,000	$157,000	$184,000	New Position

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
To be Implemented March 14, 2021
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Recreational Therapist	H	487	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Registered Dietitian	I	57	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	RN (PACE)	M	480	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Analyst Int	M	534	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Security Officer	B	311	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker	J	463	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker Sr	K	690	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Special Counsel	T	317	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Staff Attorney	P	195	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Supervisor Claims	I	219	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Supervisor Encounters	I	253	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Finance	M	419	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
To be Implemented March 14, 2021
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000	Revised job title and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Technical Analyst Int	J	64	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Technical Analyst Sr	L	75	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Technical Writer	H	247	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Technical Writer Sr	J	470	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Therapy Aide	E	521	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Training Administrator	I	621	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Training Program Coordinator	H	471	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Translation Specialist	B	241	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Web Architect	N	366	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 03/04/2021

CalOptima – Annual Base Salary Schedule – Revised March 4, 2021, to be implemented March 14, 2020.
Effective as of May 1, 2014

Summary of Changes to Salary Schedule
GA.8058 Salary Schedule Attachment A

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Accountant	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Accountant Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Accountant Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Accounting Clerk	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2021
Accounting Clerk Sr	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Activity Coordinator (PACE)	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Actuarial Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Actuarial Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Actuary	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Administrative Assistant	~~H~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$44,000	~~$42,224~~	$51,000	~~$50,648~~	$58,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Analyst	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Analyst Sr	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2021
Applications Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Applications Analyst Int	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Applications Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
~~Assistant~~ Associate Director	~~O~~	P	Revised Job Title to be consistent and pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2021
Associate Director Customer Service	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2021
Associate Director Grievance & Appeals (Proposed Title)	N/A	P	New position. Department requested new title to provide support and oversight of this function.		$117,000		$141,000		$165,000	March 2021
Associate Director Information Services	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	March 2021
~~Associate Director Provider Network~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Auditor	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Auditor Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Behavioral Health Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Biostatistics Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Board Services Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Business Analyst	J		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$65,000	~~$53,352~~	$78,000	~~$65,624~~	$91,000	March 2021
Business Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Business Systems Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Buyer	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2021
Buyer Int	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Buyer Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Care Manager	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Care Transition Intervention Coach (RN)	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Certified Coder	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Certified Coding Specialist	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Certified Coding Specialist Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Change Control Administrator	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Change Control Administrator Int	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2021
~~Change Management Analyst Sr~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Chief Counsel	~~T~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$289,000	~~$266,968~~	$361,000	~~$336,024~~	$433,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Chief Executive Officer	~~V~~	Z	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$319,740~~	$400,000	~~$431,600~~	$500,000	~~$543,600~~	$600,000	March 2021
Chief Financial Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$289,000	~~$320,216~~	$361,000	~~$403,312~~	$433,000	March 2021
Chief Information Officer	~~T~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$246,000	~~$266,968~~	$307,000	~~$336,024~~	$368,000	March 2021
Chief Medical Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$289,000	~~$320,216~~	$361,000	~~$403,312~~	$433,000	March 2021
Chief Operating Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$289,000	~~$320,216~~	$361,000	~~$403,312~~	$433,000	March 2021
Claims - Lead	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Claims Examiner	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2021
Claims Examiner - Lead	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021
Claims Examiner Sr	~~I~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$48,000	~~$46,384~~	$55,000	~~$55,640~~	$62,000	March 2021
Claims QA Analyst	~~I~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$48,000	~~$46,384~~	$55,000	~~$55,640~~	$62,000	March 2021
Claims QA Analyst Sr.	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021
Claims Recovery Specialist	~~I~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$51,000	~~$46,384~~	$59,000	~~$55,640~~	$67,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Claims Resolution Specialist	~~I~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$51,000	~~$46,384~~	$59,000	~~$55,640~~	$67,000	March 2021
Clerk of the Board	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Clinical Auditor	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Clinical Auditor Sr	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Clinical Documentation Specialist (RN)	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2021
Clinical Pharmacist	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Clinical Systems Administrator	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Clinician (Behavioral Health)	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Communications Specialist	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2021
Community Partner	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Community Partner Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2021
Community Relations Specialist	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Community Relations Specialist Sr	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Compliance Claims Auditor	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Compliance Claims Auditor Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2021
Contract Administrator	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Contracts Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Contracts Manager Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Contracts Specialist	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Contracts Specialist Int	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Contracts Specialist Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Controller	~~Q~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$182,000	~~$154,440~~	$227,000	~~$194,480~~	$272,000	March 2021
Credentialing Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Credentialing Coordinator - Lead	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Customer Service Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Customer Service Rep	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2021
Customer Service Rep - Lead	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Customer Service Rep Sr	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2021
Data Analyst	~~K~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$65,000	~~$61,360~~	$78,000	~~$75,504~~	$91,000	March 2021
Data Analyst Int	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Data Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Data and Reporting Analyst - Lead	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2021
Data Entry Tech	~~F~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$36,000	~~$34,840~~	$41,000	~~$41,808~~	$46,000	March 2021
Data Warehouse Architect	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Data Warehouse Programmer/Analyst	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
~~Data Warehouse Project Manager~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Data Warehouse Reporting Analyst	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Data Warehouse Reporting Analyst Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Database Administrator	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Database Administrator Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Deputy Chief Counsel	~~S~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$246,000	~~$222,352~~	$307,000	~~$280,072~~	$368,000	March 2021
Deputy Chief Medical Officer	~~T~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$246,000	~~$266,968~~	$307,000	~~$336,024~~	$368,000	March 2021
Deputy Clerk of the Board	M	K	Department requested new title to support Clerk duties and responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
~~Director Accounting~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Director Applications Management~~	~~R~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Audit & Oversight	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Director Behavioral Health Services	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2021
Director Budget and Procurement	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2021
~~Director Business Development~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Director Business Integration~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Case Management	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2021
Director Claims Administration	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Director Clinical Outcomes~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Clinical Pharmacy	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2021
Director Coding Initiatives	~~P~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$154,000	~~$128,752~~	$193,000	~~$162,032~~	$232,000	March 2021
Director Communications	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021
~~Director Community Relations~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Director Configuration & Coding~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Contracting	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144.000	~~$128,752~~	$174.000	~~$162,032~~	$204,000	March 2021
~~Director COREC~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Customer Service	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021
~~Director Electronic Business~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Enterprise Analytics	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Director Facilities	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2021
~~Director Finance & Procurement~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Financial Analysis	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2021
Director Financial Compliance	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Fraud Waste & Abuse and Privacy	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Director Government Affairs	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021
Director Grievance & Appeals	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021
~~Director Health Services~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Human Resources	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2021
Director Information Services	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2021
Director Long Term Support Services	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2021
~~Director Medi-Cal Plan Operations~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Network Management	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021
~~Director OneCare Operations~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Director Organizational Training & Education~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director PACE Program	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2021
Director Population Health Management	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	March 2021
Director Process Excellence	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Director Program Implementation	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Director Project Management~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Provider Data Quality	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	March 2021
~~Director Provider Services~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Director Public Policy~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Purchasing (Proposed Title)	N/A	Q	New Position. Department requested new title to provide support and oversight of this function.		$130,000		$157,000		$184,000	March 2021
~~Director Quality (LTSS)~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Quality Analytics	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Director Quality Improvement	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Regulatory Affairs and Compliance	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Director Strategic Development	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2021
~~Director Systems Development~~	~~R~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Director Utilization Management	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2021
Director Vendor Management	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2021
~~Disease Management Coordinator~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Disease Management Coordinator - Lead~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~EDI Project Manager~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Enrollment Coordinator (PACE)	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Enterprise Analytics Manager	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2021
Executive Administrative Services Manager	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2021
Executive Assistant	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Executive Assistant to CEO	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Executive Director Clinical Operations	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Executive Director Compliance	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Executive Director Human Resources	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Executive Director Network Operations	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Executive Director Operations	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Executive Director Program Implementation	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Executive Director Public Affairs	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Executive Director Quality & Population Health Management	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Executive Director, Behavioral Health Integration	~~S~~	U	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$209,000	~~$222,352~~	$261,000	~~$280,072~~	$313,000	March 2021
Facilities & Support Services Coord - Lead	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2021
Facilities & Support Services Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Facilities & Support Services Coordinator, Sr (Proposed title)	N/A	F	Department requesting new title due to growth and to establish levels.		$51,000		$59,000		$67,000	March 2021
Facilities Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Financial Analyst	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Financial Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Financial Reporting Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
~~Gerontology Resource Coordinator~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Graphic Designer	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Grievance & Appeals Nurse Specialist	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Grievance Resolution Specialist	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021
Grievance Resolution Specialist - Lead	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Grievance Resolution Specialist Sr	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Health Coach	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Health Educator	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Health Educator Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Health Network Liaison Specialist (RN)	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021
Health Network Oversight Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
HEDIS Case Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~HEDIS Case Manager (LVN)~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Help Desk Technician	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Help Desk Technician Sr	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	March 2021
HR Assistant	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2021
HR Business Partner	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2021
~~HR Compensation Specialist Sr~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
HR Coordinator	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
HR Representative	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
HR Representative Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
HR Specialist	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
HR Specialist Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2021
~~HRIS Analyst Sr~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~ICD-10 Project Manager~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Infrastructure Systems Administrator	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Infrastructure Systems Administrator Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Inpatient Quality Coding Auditor	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Intern	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2021
Investigator Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
IS Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
IS Project Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
IS Project Manager Sr	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2021
IS Project Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
IS Project Specialist Sr	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021
Kitchen Assistant	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2021
~~Legislative Program Manager~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Licensed Clinical Social Worker	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Litigation Support Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
LVN PACE	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
LVN Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Mailroom Clerk	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2021
Manager Accounting	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2021
Manager Actuary	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2021
~~Manager Applications Management~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Audit & Oversight	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Behavioral Health	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Business Integration	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Case Management	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2021
Manager Claims	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2021
Manager Clinic Operations	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Manager Clinical Pharmacist	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Coding Quality	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2021
Manager Communications	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2021
Manager Community Relations	~~M~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$95,000	~~$81,120~~	$114,000	~~$99,840~~	$133,000	March 2021
Manager Contracting	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Creative Branding	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Manager Cultural & Linguistic	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Customer Service	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
~~Manager Decision Support~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Electronic Business	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
~~Manager Employment Services~~	~~N~~	N/A	Job title is not in use nor is it planned for use.	~~$71,760~~		~~$93,184~~		~~$114,712~~		March 2021
Manager Encounters	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Manager Environmental Health & Safety	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2021
~~Manager Facilities~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Finance	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Financial Analysis	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2021
Manager Government Affairs	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2021
Manager Grievance & Appeals	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2021
~~Manager Health Education~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Manager HEDIS~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Human Resources	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Information Services	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2021
~~Manager Information Technology~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Manager Integration Government Liaison~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Long Term Support Services	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Marketing & Enrollment (PACE)	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Manager Marketing and Outreach	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2021
~~Manager Medical Data Management~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Manager Medi-Cal Program Operations~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Member Liaison Program	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Manager Member Outreach & Education	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
~~Manager Member Outreach Education & Provider Relations~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager MSSP	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager OneCare Clinical	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2021
Manager OneCare Customer Service	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
~~Manager OneCare Regulatory~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Manager OneCare Sales~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Marketing & Outreach	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Manager PACE Center	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Population Health Management	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Manager Process Excellence	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Program Implementation	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
~~Manager Project Management~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Provider Data Management Services	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Manager Provider Network	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Provider Relations	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Manager Provider Services~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Purchasing	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2021
Manager QI Initiatives	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Manager Quality Analytics	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Manager Quality Improvement	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Manager Regulatory Affairs and Compliance	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
Manager Reporting & Financial Compliance	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Strategic Development	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2021
~~Manager Strategic Operations~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Manager Systems Development~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Manager Utilization Management	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2021
Marketing and Outreach Specialist	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021
Medical Assistant	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2021
Medical Authorization Asst	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Medical Case Manager	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021
Medical Case Manager (LVN)	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2021
Medical Director	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$221,400	~~$222,352~~	$276,300	~~$280,072~~	$331,200	March 2021
Medical Records & Health Plan Assistant	~~G~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$30,576~~	$38,000	~~$38,272~~	$44,000	~~$45,968~~	$50,000	March 2021
Medical Records Clerk	~~E~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$38,000	~~$31,720~~	$44,000	~~$37,960~~	$50,000	March 2021
Medical Services Case Manager	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Member Liaison Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021
MMS Program Coordinator	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Nurse Practitioner (PACE)	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2021
Occupational Therapist	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021
Occupational Therapist Assistant	~~M~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$59,000	~~$81,120~~	$68,000	~~$99,840~~	$77,000	March 2021
Office Clerk	~~C~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$21,008~~	$36,000	~~$26,208~~	$41,000	~~$31,408~~	$46,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
OneCare Operations Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
OneCare Partner - Sales	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	March 2021
OneCare Partner - Sales (Lead)	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
OneCare Partner - Service	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021
OneCare Partner (Inside Sales)	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Outreach Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Paralegal/Legal Secretary	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Payroll Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Payroll Specialist Sr	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Performance Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Personal Care Attendant	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2021
Personal Care Attendant - Lead	~~E~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$38,000	~~$31,720~~	$44,000	~~$37,960~~	$50,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Personal Care Coordinator	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021
Personal Care Coordinator Sr	~~J~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$44,000	~~$53,352~~	$51,000	~~$65,624~~	$58,000	March 2021
Pharmacy Resident	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Pharmacy Services Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021
Pharmacy Services Specialist Int	~~J~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$44,000	~~$53,352~~	$51,000	~~$65,624~~	$58,000	March 2021
Pharmacy Services Specialist Sr	~~K~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$48,000	~~$61,360~~	$55,000	~~$75,504~~	$62,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Physical Therapist	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021
Physical Therapist Assistant	~~M~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$59,000	~~$81,120~~	$68,000	~~$99,840~~	$77,000	March 2021
Policy Advisor Sr	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2021
Privacy Manager	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2021
Privacy Officer	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2021
Process Excellence Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Program Assistant	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021
Program Coordinator	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2021
Program Development Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Program Manager	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Program Manager Sr	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2021
Program Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Program Specialist Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Program Specialist Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Program/Policy Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Program/Policy Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Programmer	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2021
Programmer Int	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Programmer Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Project Manager	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Project Manager - Lead	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2021
Project Manager Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Project Specialist	~~K~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$48,000	~~$61,360~~	$55,000	~~$75,504~~	$62,000	March 2021
Project Specialist Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Projects Analyst	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Provider Data Management Services Coordinator	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2021
Provider Data Management Services Coordinator Sr	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021
Provider Enrollment Manager	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Provider Network Rep Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Provider Network Specialist	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Provider Network Specialist Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Provider Office Education Manager	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Provider Relations Rep	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Provider Relations Rep Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Publications Coordinator	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
QA Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
QA Analyst Sr	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2021
QI Nurse Specialist	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
QI Nurse Specialist (LVN)	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Receptionist	~~F~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$38,000	~~$34,840~~	$44,000	~~$41,808~~	$50,000	March 2021
Records Manager (Proposed title)	N/A	Q	Department requested new title due to growth of duties.		$130,000		$157,000		$184,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Recreational Therapist	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2021
~~Recruiter~~	~~L~~	N/A	Job title is not in use nor is it planned for use.							March 2021
~~Recruiter Sr~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Registered Dietitian	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Regulatory Affairs and Compliance Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Regulatory Affairs and Compliance Analyst Sr	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2021
Regulatory Affairs and Compliance Lead	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
RN (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Security Analyst Int	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Security Analyst Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Security Officer	~~F~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$38,000	~~$34,840~~	$44,000	~~$41,808~~	$50,000	March 2021
SharePoint Developer/Administrator Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021
Social Worker	~~K~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$65,000	~~$61,360~~	$78,000	~~$75,504~~	$91,000	March 2021
Social Worker, Sr	~~L~~	K	Pay range adjustment based on Grant Thornton	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
			and internal evaluation of job responsibilities.							
Special Counsel	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2021
~~Sr Director Regulatory Affairs and Compliance~~	~~R~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Sr Manager Financial Analysis	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2021
~~Sr Manager Government Affairs~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Sr Manager Human Resources	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2021
Sr Manager Information Services	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	March 2021
~~Sr Manager Provider Network~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Staff Attorney	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Staff Attorney, Sr.	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2021
Supervisor Accounting	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2021
Supervisor Audit and Oversight	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Behavioral Health	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Budgeting	~~M~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$95,000	~~$81,120~~	$114,000	~~$99,840~~	$133,000	March 2021
Supervisor Case Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Claims	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Supervisor Coding Initiatives	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2021
Supervisor Credentialing	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Supervisor Customer Service	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Supervisor Data Entry	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Supervisor Day Center (PACE)	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Dietary Services (PACE)	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2021
Supervisor Encounters	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Supervisor Facilities	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Supervisor Finance	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Grievance and Appeals	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
~~Supervisor Health Education~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Supervisor Information Services	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Long Term Support Services	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Member Outreach and Education	M	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2021
Supervisor MSSP	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Nursing Services (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor OneCare Customer Service	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2021
Supervisor Payroll	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Pharmacist	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2021
Supervisor Population Health Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor ~~(Provider Enrollment)~~ Provider Data Management Services (Revised)	K		Title changed due to department name change. Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$70,000	~~$61,360~~	$84,000	~~$75,504~~	$98,000	March 2021
Supervisor Provider Relations	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Supervisor Quality Analytics	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2021
Supervisor Quality Improvement	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Regulatory Affairs and Compliance	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Social Work (PACE)	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
~~Supervisor Systems Development~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Supervisor Therapy Services (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Supervisor Utilization Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
~~Systems Manager~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2021
Systems Network Administrator Int	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Systems Network Administrator Sr	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2021
Systems Operations Analyst	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2021
Systems Operations Analyst Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2021
Technical Analyst Int	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2021
Technical Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2021
Technical Writer	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2021

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Technical Writer Sr	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2021
Therapy Aide	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2021
Training Administrator	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2021
Training Program Coordinator	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2021
Translation Specialist	~~G~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$30,576~~	$38,000	~~$38,272~~	$44,000	~~$45,968~~	$50,000	March 2021
Web Architect	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2021

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Action

Receive and file the 2020 CalOptima Quality Improvement Program Evaluation

Background

The 2020 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities initiated in 2019 which impacted results in 2020, as well as activities undertaken during the first three quarters of the 2020 calendar year to improve health care and services available to CalOptima members. The 2020 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2021 QI Program and its Work Plan.

The year 2020 is unprecedented as a result of the COVID-19 pandemic. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance's with flexibility in regulations addressing member access to care during the pandemic. It addressed Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth; APL 19-009 Supplement: Emergency Telehealth Guidance — COVID-19 Pandemic; and CMS' telehealth guidelines. The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services during the COVID-19 pandemic.

CalOptima pivoted quickly in response to the pandemic including acceleration of the Virtual Care Strategy, expanding access to virtual mental health care with trauma informed care capabilities, and implementing a hybrid approach to member outreach and education to ensure patient safety during the pandemic. CalOptima continued to focus on advancing QI initiatives to achieve 2020 QI goals and objectives to provide members with access to quality health care services in person or leveraging telehealth technology.

Discussion

Accomplishments in 2020

CalOptima achieved many of its organizational objectives in 2020:

- Recognized by DHCS as the highest performing Medicaid plan in California.
- All DHCS managed care accountability set (MCAS) measures required to achieve a Minimum Performance Level (MPL) were met in measurement year (MY) 2019. This is a significant achievement as the DHCS raised the MPL from the 25th to the 50th national percentile for MY2019.

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- Performed successful incentive outreach to members to obtain preventive care. In 2019, there were outreach programs which demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, breast and cervical cancer screening.
- CalOptima's comprehensive health network (HN) and CalOptima Community Network (CCN) Pay for Value (P4V) Performance Measurement Program continued to recognize and reward outstanding performance and support ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The P4V program is a significant driver of our achievement of the MPL for all DHCS required measures.
- In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 through 2020, for the Clinical Field Team (CFT) and Community Health Centers (CHCs). Telehealth visits were added due to COVID-19, while we continued providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots.
- CalOptima has been accepted to participate in the *California Heath Care and Homeless Learning Community.* CalOptima's Homeless Health Initiative was selected in October 2020 among more than 40 applications, as one that stood out to the external review committee.
- Post-acute Infection Prevention Quality Incentive (PIPQI) was implemented on October 1, 2020 to reduce post-acute infections at 25 nursing facilities of which 12 were already participating with University California, Irvine (UCI) since Q2 2017 in the study for Share Healthcare Intervention to Eliminate Life-threatening Dissemination (SHIELD) of multi-drug resistant organisms (MDROs). In addition, CalOptima in partnership with UCI and the Orange County Health Care Agency (HCA), participated in the Orange County Nursing Home Infection Prevention program to create safety toolkits and instructional videos to reduce the spread of COVID-19 in nursing homes.
- Implemented preventive care and flu campaign in response to COVID-19 pandemic. CalOptima used a combination of interactive voice response (IVR) (landlines only), member mailings, on-hold messaging, educational videos to member website and social media platforms and infomercials on Public Broadcasting Service (PBS) Kids.

CalOptima implemented in 2020, a robust population health management (PHM) strategy to focus on various conditions ranging from cancer screenings to managing patients with multiple complex conditions. The program had strong member and provider engagement, which was monitored on a quarterly basis. In response to the COVID-19 pandemic and amplification of health disparities for persons of color, CalOptima conducted a population segment analysis based on race and ethnicity. The population segment analysis results and opportunities to improve health equity will be incorporated in the 2021 QI Program. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2020 that will continue into 2021. These initiatives are focused on long-term improvement efforts for selected high priority measures.

Recommendations for 2021

Staff propose the following recommendations to be implemented in 2021:

1. Continue member "health rewards" incentive program, specifically for preventive screenings, but expand and transition to a more comprehensive member health rewards program that reinforces reaching and maintaining health goals and narrowing gaps in care. Work collaboratively with HNs to widen the promotion of member health and wellness. Utilize a third-party vendor to offset intense staff resources required to process member incentives;
2. Intensify targeted member outreach, by utilizing multiple modes of communications per members preference, either through website, direct mailings, email, IVR calls and mobile

texting. Leverage more electronic means versus resource intensive direct member outreach, as part of a more robust user-friendly communication/touchpoint plan;

3. Continue to utilize P4V Measure set to drive improvement on MCAS measures. Staff will consider the addition of new access measures to the P4V program for MY2021;
4. Institute new behavioral health (BH) P4V program in 2021 to help drive improvement in BH measures;
5. Prioritize data bridge efforts to improve data exchanges, both at the HN level and plan level in anticipation of many hybrid measures converting to administrative measures. Continue data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 include improving access to electronic medical record systems; and remedy the lab data gap not currently available through limited contract data exchanges; and
6. Expand Virtual Care Strategy to increase access to care for members, such as BH Virtual Care visits, e-visits, e-consults and telehealth for CalOptima's Program of All-Inclusive Care for the Elderly (PACE).

During 2020, it has been a year of uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that will continue to impact lives locally, nationally and globally into 2021. Considering the appointment of three new members of the Board Quality Assurance Committee in 2020, the CalOptima QI Program and Work Plan for 2021 will be flexible to align with the new strategic goals and objectives as defined by the new Board.

Fiscal Impact

The recommended actions to approve the 2020 QI Program Evaluation do not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020–21 Operating
Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021–22 Operating Budget.

Rationale for Recommendation

The recommended actions will enable CalOptima continue to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee (Anticipated February 25, 2021) Approved 2/25/2021

Attachment

1. 2020 QI Program Evaluation

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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2020

QUALITY IMPROVEMENT EVALUATION

2020 QUALITY IMPROVEMENT EVALUATION SIGNATURE PAGE

Quality Improvement Committee Chair:

Emily Fonda, M.D., MMM, CHCQM **Date**

Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Mary Giammona, M.D. **Date**

TABLE OF CONTENTS

2020 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2020 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities initiated in 2019 which impacted results in 2020, as well as activities undertaken during the first three quarters of the 2020 calendar year to improve health care and services available to CalOptima members.

The final 2020 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2021 to the Quality Improvement Committee (QIC). The 2020 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2021 QI Program and its Work Plan.

The year 2020 is unprecedented as a result of the COVID-19 pandemic. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance's with flexibility in regulations addressing member access to care during the pandemic. It addressed Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth; APL 19-009 Supplement: Emergency Telehealth Guidance — COVID-19 Pandemic; and CMS' telehealth guidelines. The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services during the COVID-19 pandemic.

CalOptima pivoted quickly in response to the pandemic including acceleration of the Virtual Care Strategy, expanding access to virtual mental health care with trauma informed care capabilities, and implementing a hybrid approach to member outreach and education to ensure patient safety during the pandemic. CalOptima continued to focus on advancing QI initiatives to achieve 2020 Quality Improvement (QI) goals and objectives to provide members with access to quality health care services in person or leveraging telehealth technology.

CalOptima achieved many of its organizational objectives in 2020:

- Recognized by DHCS as the highest performing Medicaid plan in California.
- All DHCS managed care accountability set (MCAS) measures required to achieve a Minimum Performance Level (MPL) were met in measurement year (MY) 2019. This is a significant achievement as the DHCS raised the MPL from the 25th to the 50th national percentile for MY2019.
- Performed successful incentive outreach to members to obtain preventive care. In 2019, there were outreach programs which demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, breast and cervical cancer screening.
- CalOptima's comprehensive health network (HN) and CalOptima Community Network (CCN) Pay for Value (P4V) Performance Measurement Program continued to recognize and reward outstanding performance and support ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The P4V program is a significant driver of our achievement of the MPL for all DHCS required measures.
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(CHCs). Telehealth visits were added due to COVID-19, while we continued providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots.

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For 2020, CalOptima had adequate staffing, resources, and a well-defined quality committee structure in place to meet the required needs of the QI program. The QI program structure includes a Quality Improvement Committee (QIC), with several subcommittees reporting to the QIC, which included the Whole-Child Model Clinical Quality Committee (WCM CAC), Utilization Management Committee (UMC), Credentialing and Peer Review Committee (CPRC), Member Experience Committee (MEMX), and Grievance Appeal and Resolution (GARS) Committee. The QIC had exceptional participation from external and internal practitioners as well as staff.

CalOptima implemented in 2020, a robust population health management (PHM) strategy to focus on various conditions ranging from cancer screenings to managing patients with multiple complex conditions. The program had strong member and provider engagement, which was monitored on a quarterly basis. In response to the COVID-19 pandemic and amplification of health disparities for persons of color, CalOptima conducted a population segment analysis based on race and ethnicity. The population segment analysis results and opportunities to improve health equity will be incorporated in the 2021 QI Program. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2020 that will continue into 2021. These initiatives are focused on long-term improvement efforts for selected high priority measures.

In 2021, based on the 2020 QI Program Evaluation, CalOptima will continue its PHM strategy in alignment with CalOptima's strategic priorities to focus on activities and incentives that will improve member engagement, access to care and quality outcomes.

Recommendations for 2021

1. Continue member "health rewards" incentive program, specifically for preventive screenings, but expand and transition to a more comprehensive member health rewards program that reinforces reaching and maintaining health goals and narrowing gaps in care. Work collaboratively with HNs to widen the promotion of member health and wellness. Utilize a third-party vendor to offset intense staff resources required to process member incentives.
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3. Continue to utilize P4V Measure set to drive improvement on MCAS measures. Staff will consider the addition of new access measures to the P4V program for MY2021.
4. Institute new behavioral health (BH) P4V program in 2021 to help drive improvement in BH measures.
5. Prioritize data bridge efforts to improve data exchanges, both at the HN level and plan level in anticipation of many hybrid measures converting to administrative measures. Continue data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 include improving access to electronic medical record systems; and remedy the lab data gap not currently available through limited contract data exchanges.
6. Expand virtual care strategies to increase access to care for members, such as BH Virtual Care visits, e-visits, e-consults and telehealth for CalOptima's Program of All-Inclusive Care for the Elderly (PACE).

During 2020, it has been a year of uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that will continue to impact lives locally, nationally and globally into 2021. Considering the appointment of three new members of the Board Quality Assurance Committee in 2020, the CalOptima QI Program and Work Plan for 2021 will be flexible to align with the new strategic goals and objectives as defined by the new Board. Staff will remain agile in the shifting health care landscape while continue to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

SECTION 1: QUALITY IMPROVEMENT PROGRAM STRUCTURE

Activities in the 2020 QI Program and associated Work Plan focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for our members.

QI Program Documents

- **Annual Evaluation** — Completed a comprehensive evaluation of the QI program at the end of the fiscal year that assesses the performance of measures/indicators that are part of the QI program.
- **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI program by including "new initiatives" in the QI program description that will outline measurable goals and objectives that the organization is going to focus on in subsequent years.
- **Work Plan** — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year dependent on priorities and opportunities.
- **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to members.

Reviews of QI Documents

- CalOptima successfully completed reviews of all of the above documents with the QI committees during 2020. The documents were reviewed and approved by the CalOptima Board of Directors.
- Feedback from the practitioners that participated in the QI committee meetings were included in program documents (i.e. Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

Provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.

- The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
- The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2020. This gave the QI department a framework on how to start implementing the QI program throughout 2020. For the remainder of the year, the QI staff updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on improving performance improvement activities directed towards clinical quality,

quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up, as appropriate.

- In 2020, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives like member outreach, provider education and outreach, incentives, educational materials, etc.
- The committee also reviewed and approved the policies and procedures as they were presented to the committee throughout 2020.
- The committee reviewed and provided feedback on key reports: annual analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); access to care; complaints and appeals; etc. Part of the feedback included specific actions that CalOptima could take to improve performance.
- The committee also received quarterly reports from the CPRC, UMC, MEMX, GARS, and WCM CAC. These reports were summarized and presented to the QAC quarterly in 2020.

Assessment of QI Staff and Resources

CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI program. In 2020, there were six additions to the QI department staff to support upcoming changes to the DHCS requirements for Facility Site Review as well as support staff for Potential Quality Issue (PQI) reviews. The QI department also received support from other key departments within the organization including, but not limited to, the following:

- Quality and Enterprise Analytics
- Population Health Management
- Behavioral Health Integration
- Case Management
- Member Services (including outreach and engagement)
- Provider Relations and Contracting
- Credentialing and Facility Site Review

Review of System Resources

CalOptima has dedicated significant resources to ensuring they have adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima has the capability to generate quality reports, gaps in care reports, physician feedback reports, and other relevant reports needed in the QI program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts that can support the reporting needs of the organization.

Overall Assessment of Program Structure

At the current time, CalOptima has adequate staffing and resources required to meet the needs of the QI program in addition to organizational program requirements. However, in 2021 it may need reallocating resources to address initiatives aimed at improving Member Experience especially timely access to care. CalOptima will continue to evaluate the needs of the program through the Work Plan on a quarterly basis and add staffing and additional resources, as needed to supplement the QI department. The organization receives adequate feedback from its community practitioners in

the development and implementation of the QI initiatives and programs through the different committees. CalOptima continues to have significant participation from the Medical Directors in the development and implementation of clinical initiatives and programs throughout the year. The Medical Director(s) and QI Directors report the information back up to Senior Leadership.

SECTION 2: QUALITY & SAFETY OF CLINICAL CARE

HEDIS Overview

CalOptima annually reports HEDIS for all lines of business (LOB). HEDIS enables "apples to apples" comparison of health plan care across six domains of care:

1. **Prevention**
2. **Access and Availability of Care**
3. **Utilization**
4. **Member Experience (CAHPS)**
5. **Health Plan Descriptive Information (such as membership, language and ethnicity of membership)**
6. **New measures using Electronic Clinical Data Sources (Adult Immunization Status, Prenatal Immunization Status and Depression Screening)**

These results are annually audited by certified HEDIS Compliance Auditors. All measures fully passed audit which gives CalOptima confidence in the reliability of the results which are used to inform our QI Program and initiatives.

These clinical quality measures are used to evaluate multiple aspects of patient care including preventive care, coordination of care, patient safety, and management of chronic conditions.

Overall Performance Highlights

- Medi-Cal
  - In 2019, the MPL for California Medicaid plans was raised from the 25th to the 50th National Medicaid percentile. CalOptima achieved the new MPL for all measures in measurement year 2019.
  - Several measures showed statistically significant improvement from the prior year. Examples include Well-Child Visits for 15 months, Prenatal and Postpartum Care, Adolescent Immunizations, and Use of Opioids from Multiple Providers. CalOptima had 69% of measures at the National Medicaid 50th percentile or higher.
  - P4V program measures showed improvement, but several are still below the 50th percentile.
  - Based on the review of rates, several measures were identified as an opportunity for improvement including asthma medication ratio, lead screening in children, and follow-up care for Children prescribed ADHD medication. These measures will be monitored in the 2021 QI Work Plan.

Key Measures for Medi-Cal

Focus on new MCAS measure set required by DHCS

Measures in red indicate a decrease from MY2019 performance

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Lead Screening in Children	90th	75th
Asthma Medication Ratio	75th	50th
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	50th	25th

Key Measures for OneCare Connect (OCC)
Measures targeted for improvement are key metrics below 3 Stars or the National Medicare 50th percentile

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Care for Older Adults (Functional Status Assessment)	2 Star	2 Star
Follow-Up After Hospitalization for Mental Illness (OCC Quality Withhold)	25th	25th
Plan All-Cause Readmissions ages 65+ (OCC Quality Withhold)	1 Star	1 Star

Key Measures for OneCare (OC)

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Care for Older Adults (Functional Status Assessment)	3 Star	2 Star
Plan All Cause Readmissions	1 Star	2 Star
Diabetes Eye Exams	4 Star	2 Star

Evaluation of 2020 Priority Initiatives

CalOptima Homeless Health Initiative

In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 through 2020, for the Clinical Field Team (CFT) and Community Health Centers (CHCs). In addition to providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots, telehealth visits were added due to the COVID-19 pandemic. The CFT received 801 calls from CalOptima's Homeless Response Team, which yielded 686 members being treated, of which 439 were CalOptima members. There have also been 138 referrals to recuperative care.

Since implementation, Homeless Clinical Access Program (HCAP) has onboarded nine community health centers of which seven are still actively participating. Since August 2019, HCAP has been in the field for over 1,500 hours, paid out $300K in provider incentives and has treated 1,228 homeless participants (CalOptima and non-CalOptima members).

Next steps include assessing COVID-19 impacts, determining ongoing needs and evaluation of data and outcomes.

P4V Program

CalOptima implemented a comprehensive HN P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The comprehensive P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board. Annually, the CalOptima staff conducts a review of the current measures and their performance over time.

Based on a 2018 retrospective longitudinal QI performance review, although CalOptima consistently met the MPL, overall quality performance trends have been flat over the past five years. This trend is

very consistent with the California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009–2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, 59% remained unchanged or declined. CalOptima's HNs provided feedback including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data.

Based on the feedback, a new methodology has been adopted for MY2020–2021, which aims for greater transparency, consistency, and administrative simplification. The new HN Quality Rating (HNQR) methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, CMS Star Rating Status, newly required DHCS MCAS and/or overall NCQA Health Plan Rating. This new methodology was approved by the CalOptima Board of Directors in February 2020. The new methodology also received approval from the CalOptima Board of Directors to double the per member per month (PMPM) incentive to network providers and HNs for the P4V program.

Evaluation of Initiatives for Specific HEDIS Measures

This evaluation of quality initiatives focuses on activities performed in 2019 on priority measures identified in the QI Work Plan and to impact the HEDIS 2020 (MY2019) rates. This evaluation also describes current 2020 quality initiatives and gives preliminary insight as to barriers and lessons learned that inform the development of the 2021 QI Work Plan.

Please note: All HEDIS results equate to the prior MY, e.g., HEDIS 2020 refers to MY2019. All graphs reflecting HEDIS 2020 Results show a trend analysis for MY2017–2019.

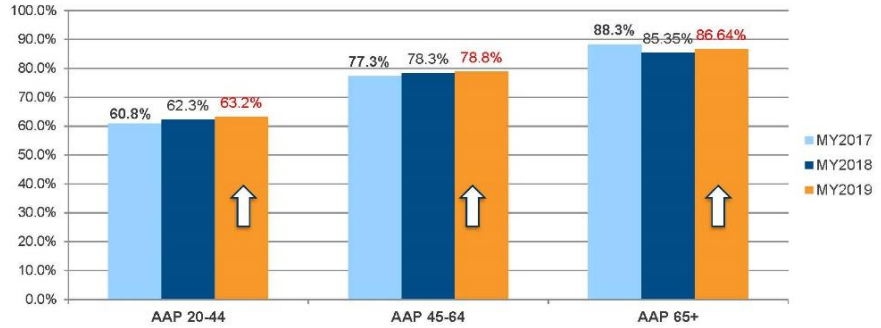
Kaiser members were excluded from this program evaluation since the QI Program and activities are fully delegated to Kaiser, thus they were not included in CalOptima quality initiatives. Please note, however, that Kaiser members *are* included as part of the HEDIS 2020 final rate calculations.

Adult's Access to Preventive/Ambulatory Services (AAP): Medi-Cal

The table below shows a trend analysis for Medi-Cal Adult's Access to Preventive/Ambulatory Services (AAP) for the MY 2017–2019. The rates have steadily increased for AAP the past three years. However, a decline is anticipated in the 2020 MY rates due to observed dip in preventive care and well care visits during the COVID-19 pandemic. This measure is incentivized in our P4V program and has helped the improvement of this measure.

AAP Table: Trending HEDIS Rates MY2017–2019 Results: Medi-Cal

HEDIS 2020 Results: Medi-Cal
Annual Visits to PCP's



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Services (AAP) 20-44	78.63%	82.36%	85.30%	71.59%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 45-64	86.32%	88.84%	90.88%	81.68%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 65+	88.07%	92.07%	94.70%	88.07%	P4V

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

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2019 Adult's AAP Initiatives: Medi-Cal

- Implemented HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness. This program is monitored by the Program Manager, and data collection is tracked and monitored monthly. It is important to continue implementing the program activities as it is still in the infancy stage.
- Promoted the preventive health care services such as breast cancer screening, cervical cancer screening and colorectal cancer screenings for the appropriate age groups and populations. These activities subsequently impacted the AAP measure by engaging members to access health care services. For more information, refer to the breast cancer screening, cervical cancer screening and colorectal cancer screening sections.

2020 Adult's AAP Initiatives: Medi-Cal

- Implemented HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.
- Promotion of preventive health care services such as breast cancer screening, cervical cancer screening and colorectal cancer screenings for the appropriate age groups and populations. These activities subsequently impacted the AAP measure.

Barriers

- Due to the COVID-19 pandemic, there was a drop in well-care visits during March–August 2020. CalOptima's June 2020 prospective rate reports show a decline when compared to the same time last year. The community is reluctant to go in for their routine well-care visits and immunizations due to COVID-19. CalOptima will continue our efforts to promote well-care visits during this time.

Opportunities for Improvement

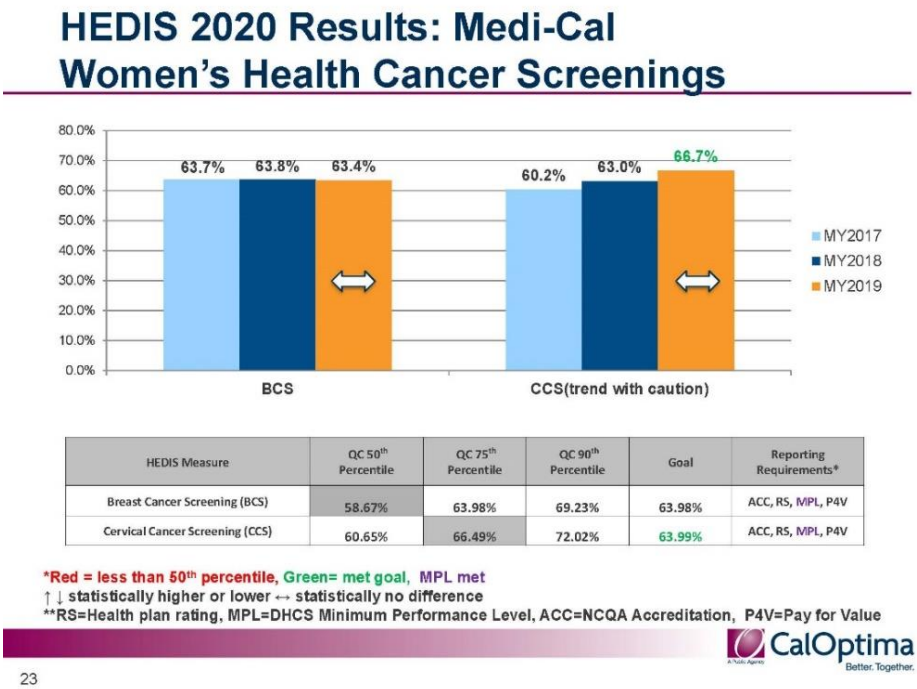
- Continue to promote appropriate well-care visits and immunizations for adults during this time.
- Continue the HCAP services for person experiencing homelessness in Orange County.
- Continue with implementing appropriate member and provider incentive (the term "health reward" is used interchangeably) programs for 2021 to increase preventive health care screenings and tests.
- Keep as a QI Work Plan priority due to catch up that will need to occur due to COVID-19.
- Consider developing a general well care visit member incentive or anticipatory guidance to promote preventative visits in light of member hesitation due to COVID-19.
- Leverage alternative member outreach modality such as mobile text messaging to promote well care visits safely.

Preventive Health Screenings (BCS/CCS/COL)

Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS): Medi-Cal

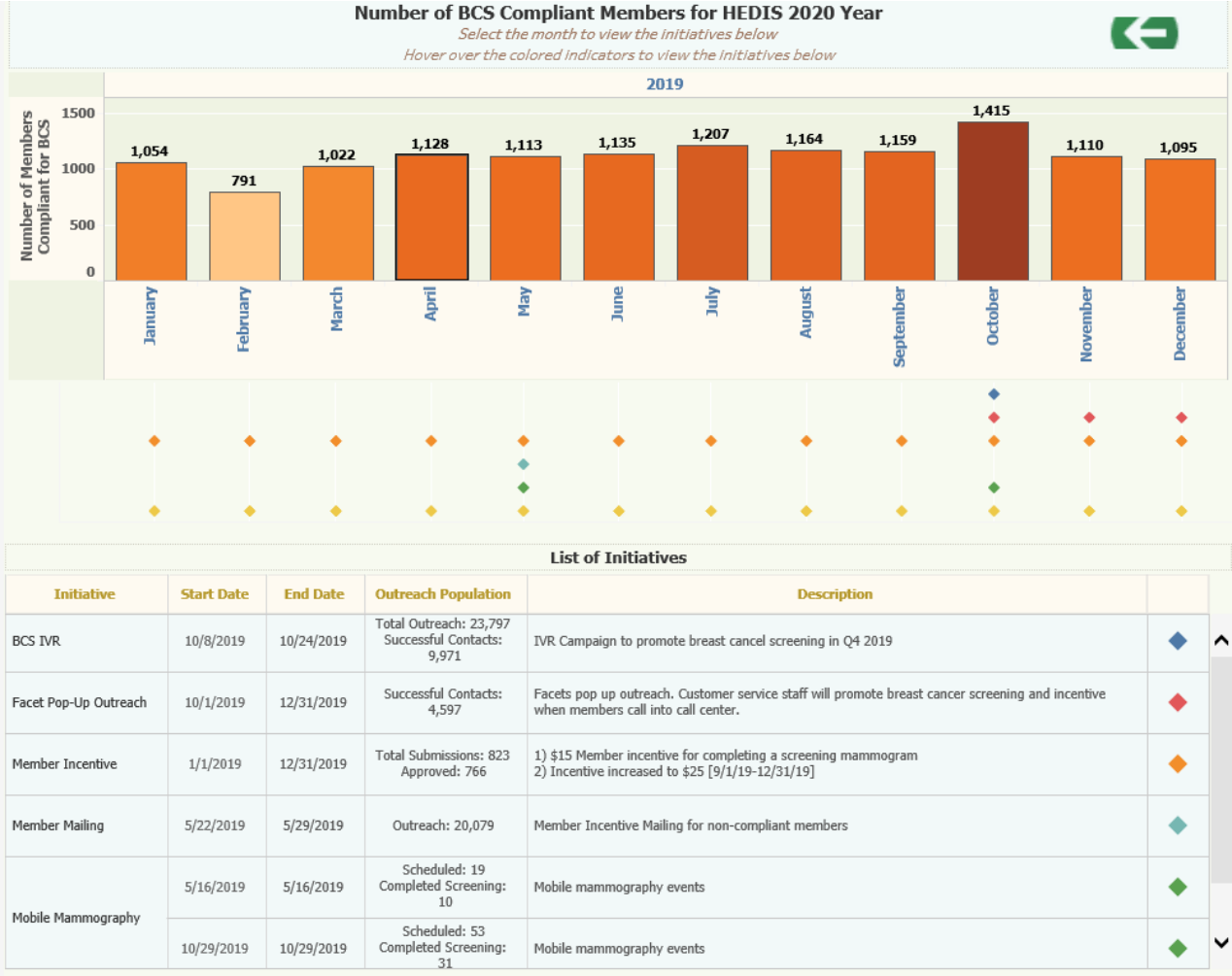
In 2020, CalOptima had initiatives for BCS and CCS cancer screenings. The table below shows a trend analysis of Medi-Cal BCS and CCS for the last three MY2017–2019. The rates have been steady for BCS but show improvement for CCS. However, we anticipate some decline in the 2020 MY rates due to the COVID-19 pandemic.

BCS/CCS Table 1: Trending HEDIS Rates MY2017-2019 Results: Medi-Cal



BCS Table 2: Impact of BCS Targeted Interventions on HEDIS 2020 Year: Medi-Cal

The table below shows the number of unique members who received a BCS mammogram month by month and the impact of interventions throughout the year. While the rate remained steady throughout the year, the month with the highest jump in BCS screenings occurred in October 2019, right after the amount of the member incentive raised from $15 to $25. In addition, IVR outreach, FACETS member outreach and mobile mammography initiatives all took place in October 2019. Breast Cancer Awareness month also in October.



2019 BCS Initiatives: Medi-Cal

1. BCS Member Incentive 01/01/2018–12/31/2019

A. Description

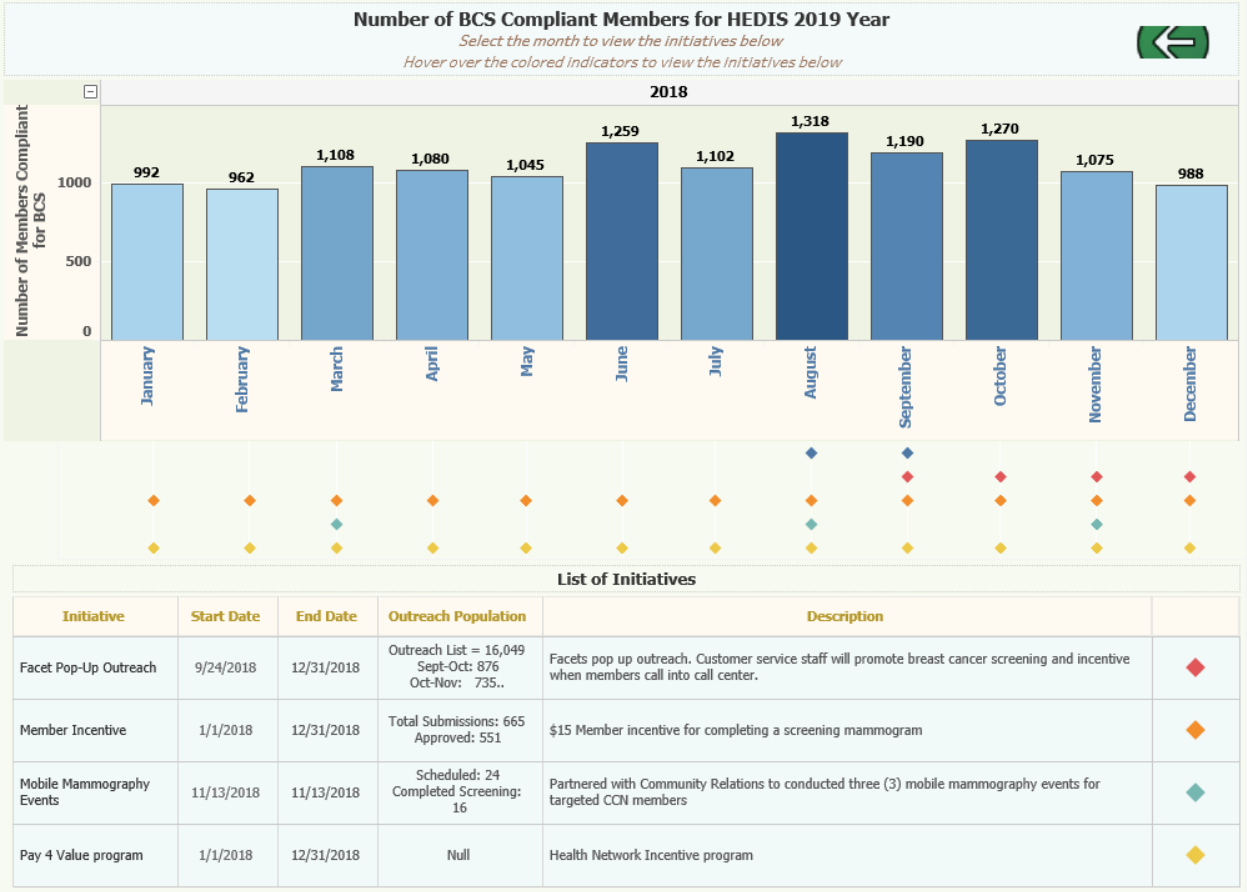
In August 2018, 16,340 eligible Medi-Cal members ages 50–74 were mailed a BCS incentive form for a $15 gift card. In May 2019, 20,079 CalOptima Medi-Cal members ages 50–74 identified as needing a screening mammogram completed before 12/31/2019, were mailed a $15 incentive form in May 2019. The incentive amount was changed in September 2019 from $15 to $25. The mailing was not repeated due to limited budget for mailing; however, members were made aware of the incentive via IVR robocall campaign.

BCS Table 3: Breast Cancer Screening Incentive Mailing MY2018–MY2019

BCS Incentive Forms	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2018	16,340	626	482	32,059	1.50%
2019	20,079	753	594	32,940	1.80%

NOTE: The HEDIS denominator was used to calculate the participation rate.

BCS Table 4: The table below shows the BCS initiatives for the HEDIS 2019 (MY2018) year. The data shows a steady number of members compliant for BCS throughout the year with only a slight rise in August 2018 when the BCS member incentive form was mailed to eligible members.



List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Facet Pop-Up Outreach	9/24/2018	12/31/2018	Outreach List = 16,049 Sept-Oct: 876 Oct-Nov: 735..	Facets pop up outreach. Customer service staff will promote breast cancer screening and incentive when members call into call center.
Member Incentive	1/1/2018	12/31/2018	Total Submissions: 665 Approved: 551	$15 Member incentive for completing a screening mammogram
Mobile Mammography Events	11/13/2018	11/13/2018	Scheduled: 24 Completed Screening: 16	Partnered with Community Relations to conducted three (3) mobile mammography events for targeted CCN members
Pay 4 Value program	1/1/2018	12/31/2018	Null	Health Network Incentive program

B. Analysis

1. In 2018, of the 16,340 members mailed the incentive form in August 2018, 14,521 remained in the denominator for the HEDIS 2019 BCS measure. Of those, 1,603 members completed a BCS after the mail drop date with a rate of 5.00% (1,603/32,059). Of the 626 BCS incentive form submissions, 482 BCS incentive form submissions remained in the BCS measure denominator. The incentive participation rate for the HEDIS 2019 BCS measure was 1.50% (482/32,059).
2. In 2019, of the 20,079 members mailed the incentive form in May 2019, 16,823 were part of the HEDIS denominator for the HEDIS 2020 BCS measure. Of those mailed the incentive a total of 753 BCS incentive forms were received, 594 members were in the BCS measure denominator. The incentive participation rate for the HEDIS 2020 BCS measures was 1.8% (594/32,940). Of the 594 HEDIS eligible forms there were 493 forms date of service (DOS) matched our claims/encounters data while 101 forms DOS did not match with a rate of 83.00%.
3. Although the participation rate increased from MY2018 to MY2019, it was minimal. Considering there was no additional interventions, other than the one-time mailing, and very little promotion, the low participation rate was expected.

C. Barriers

1. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until the end of Q1 every year. Additionally, it is unknown which percentage of mail is returned due to wrong addresses.
2. The member incentive form requires a signed/stamped attestation by the primary care provider (PCP) or imaging center. This may prevent some members from participating in the BCS incentive, on top of a perceived aversion and negative perception of the mammogram experience.
3. The low dollar amount of the incentive may not have been a big enough incentive, therefore the adjustment from $15 to $25 in September 2019.
4. Incentive was not communicated effectively to members or providers resulting in low incentive participation.
5. The merging of multiple interventions in October 2019 makes it unclear which intervention had the most impact.

D. Opportunity for Improvement

1. Due to the late September 2019 change of the dollar amount of the incentive, continue the BCS incentive through 2020 and 2021 to allow more time for members to be aware of the incentive programs offered.
2. Enhance the BCS member by utilizing multiple modes of communication via website, direct mailings, IVR calls and mobile text messaging and more direct collaboration with CCN providers and HN quality teams.
3. Messaging can be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race. Utilize Gaps in Care outreach nurses.

2. BCS FACETS Member Outreach 10/01/2019–12/31/2019

A. Description

Target CalOptima Medi-Cal members ages 50–74 that were non-compliant for BCS that have placed an inbound call to CalOptima for another need. Customer Service staff had an opportunity to promote the importance of BCS to a captive audience/member that need to complete BCS. Also, members notified of the incentive opportunity available for completing a screening mammogram.

B. Analysis

1. Customer Service was able to deliver the FACETS pop-up message to 4,597 non-compliant members. Of the 4,597 members that were targeted 1,920 members were in the denominator for the HEDIS 2020 BCS measure.
2. The rate of members that received the message for HEDIS 2020 BCS measure was 5.83% (1,920/32,940). Of the members who received the FACETS pop-up message, 133 members completed a BCS after receiving FACETS pop-up message with a rate of 0.40% (133/32,940).

C. Barriers

1. This intervention is only available to members who called into the Customer Service line and likely already proactive about their health. It is uncertain if the FACETS pop-up message was the only reason member would complete their BCS.

D. Opportunities for Improvement

1. Continue BCS FACETS member outreach as part of a more robust member communication/touchpoint plan.
2. Expand the duration of the BCS FACETS member outreach or also conduct initiative earlier in the MY as well.

3. **BCS IVR Outreach 10/08/2019–10/24/2019**
   A. **Description**
      Member outreach campaign targeted eligible CalOptima Medi-Cal members ages 50-74 that were non-compliant for BCS to encourage completion of a BCS.

   B. **Findings**

BCS Table 5: This table shows the results of non-compliant members that were targeted for the BCS IVR call campaign.

2019 BCS IVR Outreach	Successful IVR Calls	Unsuccessful IVR Calls	Total IVR Calls	Rate of Successful IVR Calls
BCS IVR Call Campaign	9,971	13,826	23,797	41.90%
HEDIS 2020 BCS Measure	1,299	11,870	13,169	9.86%

   C. **Analysis**
      1. Of the 23,797 total IVR calls made, 9,971 of the calls were listened to or completed, a rate of 41.90% (9971/23797). Of the 23,797 members that were targeted 13,169 were in the denominator for the HEDIS 2020 BCS measure. The rate of successful IVR calls for the HEDIS 2020 BCS measure was 9.86% (1,299/13,169).

   D. **Barriers**
      1. Unsuccessful IVR call was largely due to the member hanging up the call before the message was completed, no answer/busy and bad number.

   E. **Opportunities for Improvement**
      1. Expand member outreach modality beyond BCS IVR call campaign as the only method to notify members when they are due for BCS.
      2. Continue BCS IVR call campaign as part of a more robust member communication/touchpoint plan.
      3. Re-design BCS IVR call campaign to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
      4. Make use of mobile text messaging and IVR campaigns in 2021.

4. **Breast Cancer Screening (BCS) Mobile Mammography 05/16/2019; 10/29/2019**
   A. **Description:** Targeted eligible CCN Medi-Cal members ages 50–74 to complete BCS at a planned mobile mammography event at two locations. Members that attended and completed BCS received $20 gift card.
      1. Mobile mammography event held on 05/16/2019 at the Nhan Hoa Comprehensive Health Care Clinic. Mobile mammography event held 10/29/2019 at the CalOptima Westminster Satellite Office.
      2. BCS mobile mammography data was used to evaluate how many members completed BCS at one of the mobile mammography events and were included in the denominator for the HEDIS 2020 BCS measure.

B. Findings

BCS Table 6: This table shows the results of non-compliant members that were targeted for BCS mobile mammography.

BCS Mobile Mammography	Scheduled	Completed BCS Screening	HEDIS 2020 Denominator	Completed BCS Screening
BSC Mobile Mammography (Combined events)	72	41	--	--
HEDIS 2020 BCS Measure	53	28	32,940	0.09%

C. Analysis

1. Of the 72 members that were scheduled, 53 members were in the denominator for the HEDIS 2020 BCS measure. Of the 72 scheduled, 41 completed the screening. Of the 53 in the denominator, only 28 completed the screening. The rate of members that completed BCS through the event against the overall denominator for the HEDIS 2020 BCS measure was 0.09% (28/32,940).

D. Barriers

1. 43% of the scheduled members did not attend the event. The intervention is resource intensive and takes extensive planning across internal departments. Due to contractual limitations with the mobile mammography vendor, the event could only accommodate a relatively small volume of members.
2. Qualitative feedback from attendees showed significant value of bringing the service out to the community albeit it being resource intensive to support a traditionally difficult-to-reach portion of the membership.

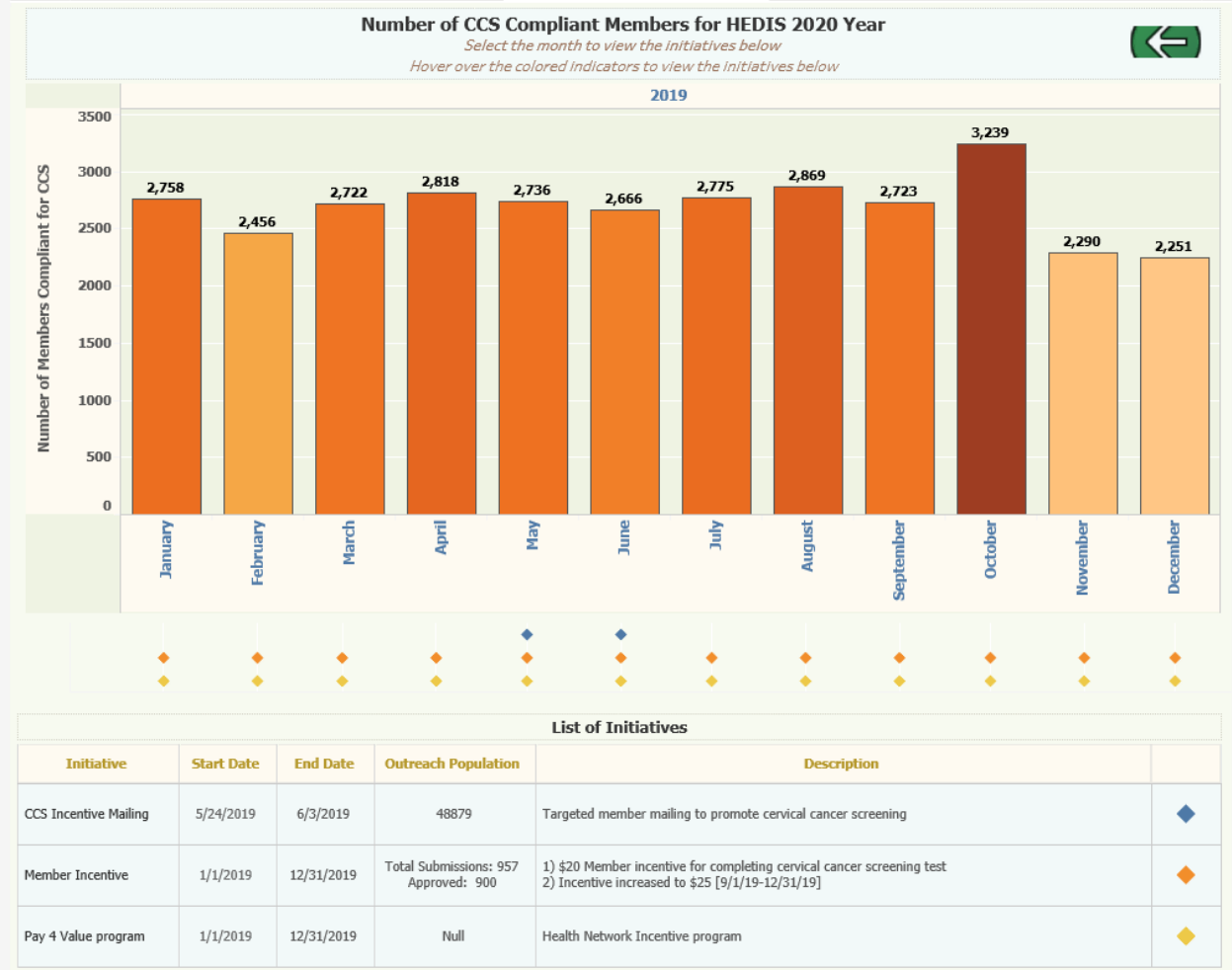
E. Opportunities for Improvement

1. Explore a less resource intensive mechanism to solicit and include qualitative feedback from attendees
2. Adapt mobile mammography events to reach greater volume of members likely to engage in geographic locations or places of gathering, possibly leveraging CalOptima's nearby imaging centers that can accommodate higher volume.

2019 Cervical Cancer Screening Initiatives: Medi-Cal

CCS Table 2: Impact of CCS Targeted Interventions on HEDIS 2020 Rates: Medi-Cal

The table below shows the number of unique members who received a pap test and the impact of interventions throughout the year. The data shows a steady number of members compliant for CCS throughout the year. The highest number of cervical screenings occurred in October 2019 when the CCS member incentive dollar amount increased from $20 to $25.



1. Cervical Cancer Screening (CCS) Member Incentive 01/01/2018–12/31/2019

A. Description

In August 2018, 66,675 eligible Medi-Cal members ages 21–64 were mailed a CCS incentive form for $20 gift card. In May 2019, 48,879 CalOptima Medi-Cal members ages 21–64 identified as needing a cervical cancer screening or pap test completed before 12/31/2019 were mailed a $20 incentive form. The incentive amount was changed in September 2019 to $25. The mailing was not repeated due to limited budget for an additional mailing; however, members were made aware of the incentive via IVR robocall campaign.

B. Findings

CCS Table 4: Cervical Cancer Screening Incentive Mailing MY2018–MY2019

CCS Incentive Forms	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2018	66,675	745	699	119,220	0.57%
2019	48,879	963	705	117,422	0.60%

NOTE: The HEDIS denominator was used to calculate the participation rate.

C. Analysis

1. In 2018, of the 66,675 members mailed the incentive form in August 2018, 56,767 remained in the denominator for the HEDIS 2019 CCS measure. 4,618 members completed a CCS after the mail drop date with a rate of 3.87% (4,618/119,220). Of the 745 CCS incentive form submissions, 699 CCS incentive form submissions remained in the CCS measure denominator. The incentive participation rate for the HEDIS 2019 CCS measure was 0.57% (699/119,220).
2 In 2019, of the 48,879 members mailed the incentive form in May 2019, 36,548 were part of the HEDIS denominator for the HEDIS 2020 CCS measure. Of those mailed the incentive, 3873 completed a screening after the mail drop with a rate of 3.30% (3,873/117,422). Of a total of 963 CCS incentive forms received, 705 members were in the CCS measure denominator. The incentive participation rate for the HEDIS 2020 CCS measures was 0.60% (705/117,422). Of the 705 HEDIS eligible forms there were 607 forms DOS matched our claims/encounters data while 98 forms DOS did not match with a rate of 86.10%.
3. Although the participation rate increased from MY2018 to MY2019, it was minimal. Considering there was no additional interventions, other than the one-time mailing, and very little promotion, the low participation rate was expected.

D. Barriers

1. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until Q2 every year. It is unknown which percentage of mail is returned due to wrong addresses as well.
2. The member incentive form requires a signed/stamped attestation by the PCP or imaging center. This may prevent some members from participating in the BCS incentive on top of a perceived aversion and negative perception of the mammogram experience.
3. The low dollar amount of the incentive may not have been a big enough incentive, therefore the adjustment from $20 to $25 in September 2019.
4. Incentive was not communicated effectively to members or providers resulting in low incentive participation.
5. The merging of multiple interventions in October 2019 makes it unclear which intervention had the most impact. A 2020 mailing to all members due for a pap test in 2020 was delayed from the original intended date in March 2020 to August 2020 due to deliberate delays in having members come in during the height of the COVID-19 pandemic.

E. Opportunities for Improvement

1. Continue the CCS incentive through 2020 and 2021 to allow more time for members to be aware of the incentive programs offered.
2. Expand member outreach beyond CCS member mailing. Heightened promotion of the CCS incentive utilizing multiple modes of communication via website, direct mailings, IVR calls and mobile text messaging and more direct collaboration with CCN providers and HN quality teams is recommended in 2020 and 2021 to see the impact and trend of incentive enhancements.
3. Redesign messaging to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
4. Utilize Gaps in Care outreach nurses.

2020 Breast Cancer Screening and Cervical Cancer Screening Initiatives: Medi-Cal

- BCS and CCS incentive mailing originally scheduled for March 2020 was delayed and mailed in August 2020 to all eligible members who were due for a BCS or CCS. To address concerns about urging preventative screenings raised by HNs, a COVID-19 disclaimer was added to all mailings encouraging members to have the discussion about any risks and to determine the best care plan for each member weighing the risk against the benefits.
- Continued monitoring and tracking member incentive for both BCS and CCS screening measures.
- Collaborate and coordinate outreach efforts with HN quality teams on call, IVR and mailed campaigns. Some HNs agreed to promote CalOptima incentives.
- Promote member incentives through website, HN and provider update faxes and communications, incentive posters for medical offices.
- IVR campaign for the CCS population in January 2020 to align with the national monthly observances.

Barriers

- Due to the COVID-19 pandemic, preventive care visits began declining in March 2020. CalOptima's June 2020 prospective rate reports show a decline when compared to the same time last year. The community was reluctant to go in for their preventive care screenings due to COVID-19.
- Members are afraid of the procedure itself and other members are afraid of the result. Both barriers are related to member understanding of the tests and treatment options available.
- Incentives were not loaded to the CalOptima website until March 2020 due to design and approval delays.
- Incentives were not mailed to target populations in March 2020 as scheduled due to COVID-19 and were delayed until August 2020.
- BCS IVR campaign scheduled for May was put on hold due to surge in COVID-19 cases, and the need to adjust messaging to include safety precautions in light of the pandemic.

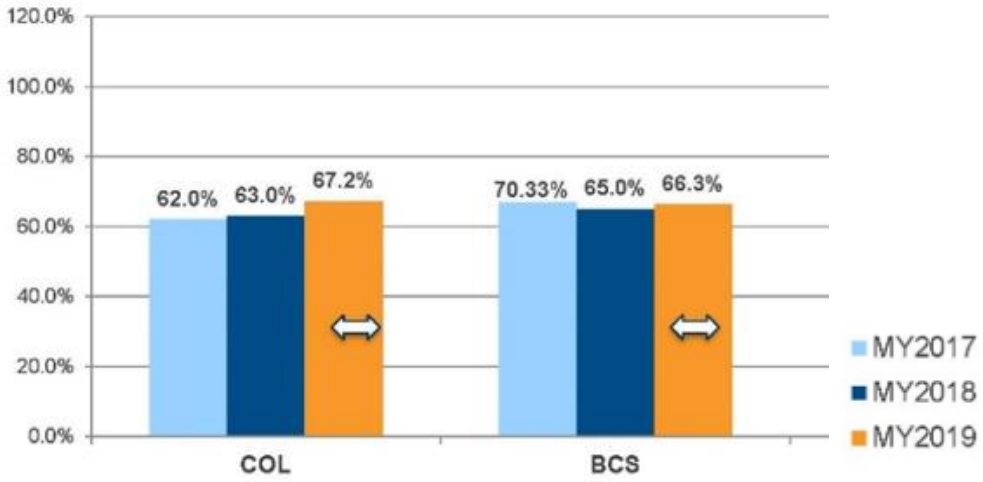
Opportunities for Improvement

- Despite negligible improvements in incentive participation rates for BCS and CCS, considering the minimal amount of outreach in MY2018 and MY2019, and due to the late nature of the upgrade for both incentives to $25, the incentive program should run through 2020-2021 to see how wider marketing and promotion in working directly with HNs and high volume providers for both incentives may impact utilization and rates.
- Retain these measures on the 2021 QI Work Plan and continue to focus on preventive care screenings including BCS and CCS to address expected dips in utilization through multi-media awareness messaging and communications.
- Expand messaging and promotion of $25 incentives for the BCS and CCS screenings appealing to the importance of not delaying due to COVID-19 and the financial benefit of the $25 gift card.

Breast Cancer Screening (BCS) and Colorectal Cancer Screening (COL): OC and OCC

The table below shows a trend analysis for OCC BCS and COL for MY2017-2019. The rates have slightly increased for BCS from 2018 to 2019. The rates for COL have gradually increased from 2017–2019. However, we anticipate some decline in the 2020 MY rates due to the COVID-19 pandemic.

HEDIS 2020 Results: OneCare Connect Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	62%	73%	80%	73%	Star, P4V
Breast Cancer Screening (BCS)	66%	76%	83%	66%	Star, P4V

2019 Breast Cancer Screening and Colorectal Cancer Screening Initiatives: OC and OCC

- CalOptima offered a $25 breast screening incentive and a $50 colorectal cancer screening incentive as two new health rewards (health reward and incentive are used interchangeably) to the Medicare population late in September 2019. To qualify for the BCS incentive program, a member must complete a screening mammography in 2019 in order to receive a $25 health reward. To qualify for the COL incentive program, a member must complete either a sigmoidoscopy or colonoscopy in 2019 in order to receive a $50 health reward. The response rates for these programs was close to zero due to a late launch in the year and no official mailing sent to eligible members due to delays with form graphic design and approval through CMS. The forms were not made available on the CalOptima website until March 2020.

2020 Breast Cancer Screening and Colorectal Cancer Screening Initiatives: OC and OCC

Continued monitoring and tracking member incentive for both screening measures.

- Official launch of new $25 OC/OCC breast cancer screening and $50 OC/OCC COL member incentives in January 2020 with HN and CCN provider notifications.
- Fillable PDF forms posted on the CalOptima website in March 2020.
- Incentive article in OCC member newsletter in Summer 2020 issue.

Barriers

- Due to the COVID-19 pandemic, there was a drop in preventive care screenings starting March 2020. CalOptima's 2020 rate reports continue to show a decline when compared to the same time last year. The community is reluctant to go in for their preventive care screenings due to COVID-19.

- Members are afraid to know the result of the tests and avoid getting screened because of that fear.
- COVID-19 added to another level of fear to get preventive care services as members have stayed away from any kind of clinic visits.
- IVR campaigns were put on hold due to a surge in COVID-19 cases to prioritize pandemic safety precautions.

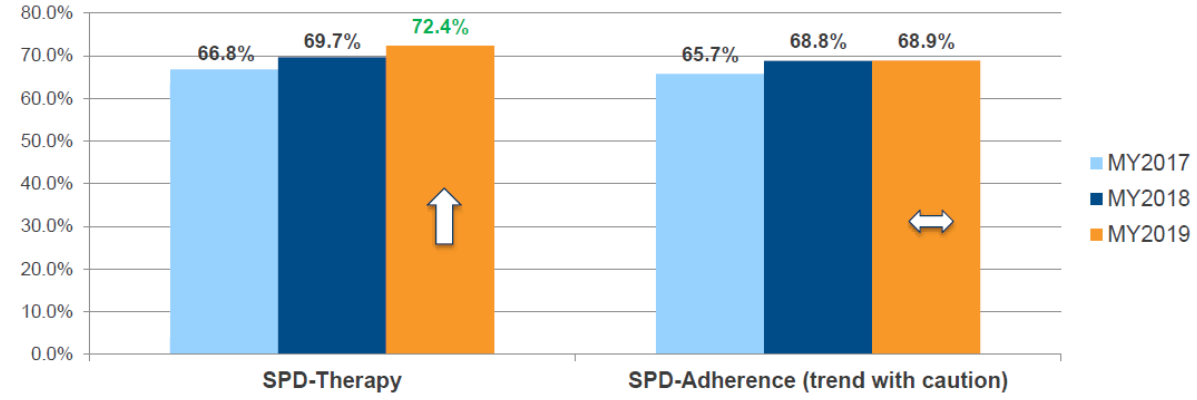
Opportunities for Improvement

- Continue both member incentives for the OC and OCC populations.
- Due to new barriers experienced by COVID-19 this year, CalOptima will retain both BCS and COL measures on the 2021 QI workplan and continue to focus on preventive care screenings to address expected dips in utilization through multi-media awareness messaging and communications.
- Expand messaging and promotion of both screening incentives appealing to the importance of not delaying due to COVID-19 and the financial benefit of the gift cards.

Statin Therapy for Patients with Diabetes (SPD)

The table below shows a trend analysis for Medi-Cal SPD measure for MY2017–2019. SPD-therapy sub measure met the MPL goal for MY2019 reaching the 90th percentile MPL. Although we did not meet goal for the SPD-adherence sub measure MY2019, we did achieve the 75th percentile satisfying the MPL. However, some decline is anticipated in the 2020 MY rates due to the COVID-19 pandemic.

SPD Table 1: HEDIS Trending Rates 2017–2019



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.65%	67.19%	70.19%	70.19%	ACC, RS
Statin Therapy for Patients with Diabetes (SPD) - adherence	59.11%	64.62%	72.03%	71.00%	ACC, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

2020 Statin Therapy for Patients with Diabetes (SPD) Initiatives: Medi-Cal, OC and OCC

1. Pharmacy Department SPD Provider Faxes 2019-2020

A. Description

CalOptima's Pharmacy department sent a list of members to providers for member outreach in order to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggested non-adherence.

SPD Table 2a and b: Pharmacy Department SPD Provider Faxes 2019–2020

QTR	Date of Fax	Total Member Count Included in Fax	# of Included MCAL Members	# of Included OC Members	# of Included OCC Members
1Q19	3/27/19	7,905	7,125	69	711
2Q19	5/23/19	9,292	8,333	94	865
3Q19	8/16/19	7360	6,429	115	816
4Q19	11/20/19	8,603	8,584	19	726

Pharmacy Department SPD Provider Faxes 2020												
Number of Members Faxed to Providers												
	Quarter 1 2020				Quarter 2 2020				Quarter 3 2020			
Sub measure	MCAL	OC	OCC	Total	MCAL	OC	OCC	Total	MCAL	OC	OCC	Total
Statin Needed	3,176	42	397	3,615	4,166	56	516	4,738	3,861	53	447	4,361
Statin Non-Adherence	2,489	22	266	2,777	1,823	13	206	2,042	2,225	35	297	2,557
Total	5,665	64	663	6,392	5,989	69	722	6,780	6,086	88	744	6,918

2. Quarterly SPD Member Mailings

A. Description

In an effort to reinforce the SPD provider faxes, a quarterly complementary member mailing was created to educate members with diabetes who are not on a statin medication or non-adherent to have the conversation with their PCP about whether a statin was right for them to reduce cardiovascular risk as a precautionary safety measure. The mailing included this message and information about statin medications. PHM sent quarterly mailings to members to improve SPD Statin Therapy and Statin Adherence measures. Identified members were either not currently on a statin medication or had an adherence rate <80% of their statin medication. Since 2019 was a planning year for this initiative, the data was finalized in November 2019 The mailer first dropped in Q1 2020 and included a cover letter prompting

the member to ask their doctor if a statin medication is right for them along with a member material about statin medication.

SPD Table 3: SPD Quarterly Member Mailings

	SPD Member Quarterly Mailings					
	Q1 2020			Q2 2020		
LOB	**Targeted Non-Compliant Members Sent Letter**	**Compliant Members After Mailing**	**Compliance Rate by Next QTR**	**Targeted Non-Compliant Members Sent Letter**	**Compliant Members After Mailing**	**Compliance Rate by Next QTR**
OC	40	32	80%	8	5	63%
OCC	276	146	53%	125	46	37%
Medi-Cal	2334	1006	43%	1007	278	28%
Total	**2650**	**1184**	45%	**1140**	**329**	29%

B. Analysis

- In Q1 2020, the compliance rate by next quarter was 80% for OC, 53% for OCC and 43% for Medi-Cal. Overall, there was a 45% compliance rate across the lines of business, by the next quarter. In Q2 2020, the compliance rate by next quarter was 63% for OC, 37% for OCC and 28% for MC and overall, we had a 29% compliance rate by the next quarter in Q2 2020. Compliance rates improved most significantly for OC members, likely because these members had greater medical needs and were more consistently under a physician's direct care.

C. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications with diabetes.

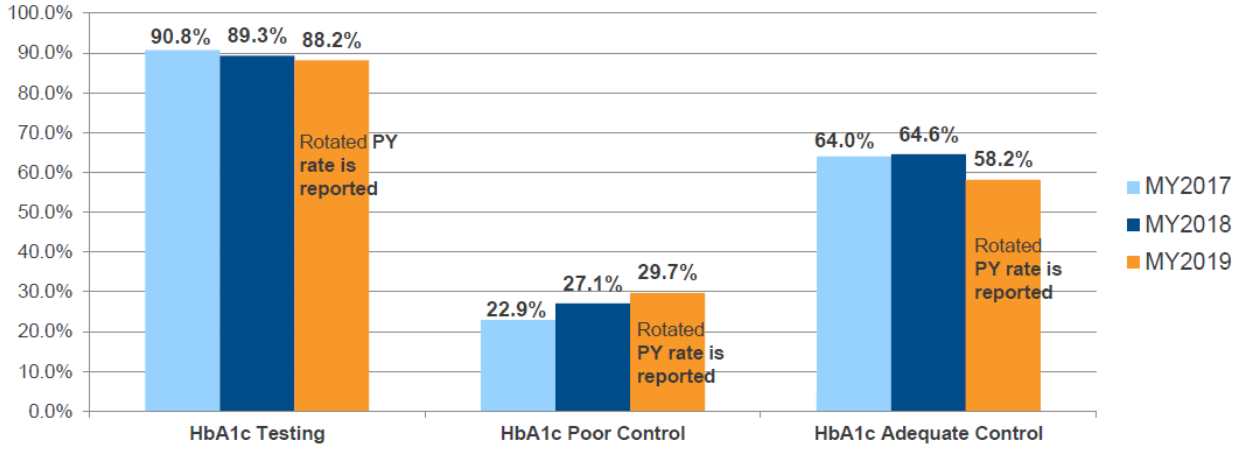
D. Opportunities for Improvement

1. Due to moderate success in affecting compliance, the quarterly faxes will continue to be sent to providers of their diabetic and quarterly member mailings to newly identified diabetic members who are not currently on a statin medication. The provide are an additional layer of support to other efforts to prevent cardiovascular risk among the diabetic population and promote safety.
2. Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
3. Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
4. Continue newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Comprehensive Diabetes Control (CDC): A1C Testing and Eye Exam

The table below shows the trend analysis for Medi-Cal Comprehensive Diabetes Care (CDC) HbA1c measure for the years 2017–2019. HbA1c Poor Control met the 75th percentile surpassing the MPL (lower is better). HbA1c Adequate Control sub measure met the 75th percentile.

CDC Table 1: HbA1cTesting and Control

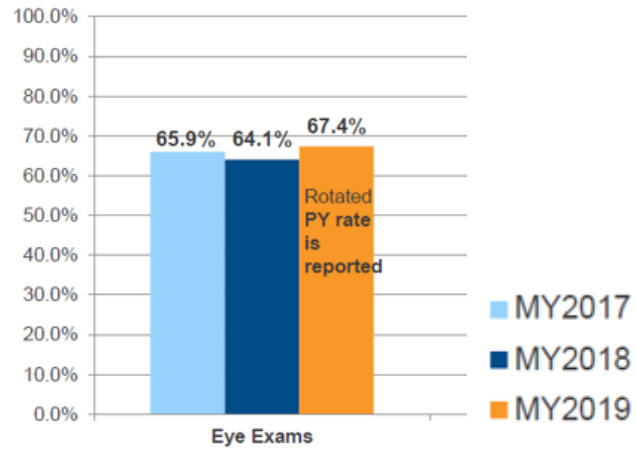


HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	88.55%	90.51%	92.94%	89.78%	MPL
HbA1c Poor Control (>9.0%) (Lower is better)	38.52%	32.85%	27.98%	27.98%	MPL
HbA1c Adequate Control (<8.0%) ++	50.97%	55.96%	60.77%	60.77%	ACC, RS, P4V

*Red = less 50th percentile, Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings
↑ ↓ statistically higher or lower ↔ statistically no difference
*RS=Health Plan Rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

CDC Table 2: Eye Exam

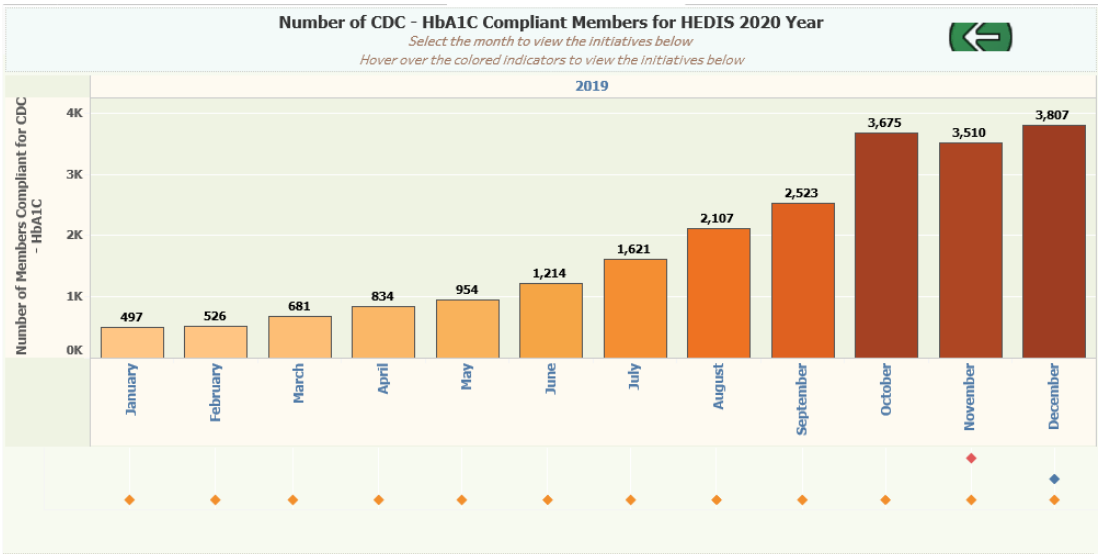
The table below shows the trend analysis for the Medi-Cal CDC Eye Exam measure for MY2017–2019. Eye Exam measure met the 50th percentile meeting the MPL.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Eye Exams	57.88%	64.23%	68.61%	64.72%	ACC, RS, P4V

CDC Table 3: HbA1C Compliant Members for HEDIS 2020

The table below shows the HbA1C initiatives for the HEDIS 2020 (MY2019) year. The data shows a gradual increase month to month even more so for June 2019 to October 2019. A factor that could have contributed to this increase may have been the distribution of the member incentive in June 2019. A slight decrease occurred in November 2019. The HbA1c IVR campaign deployment in November 2019 as well as the implementation of the Diabetes Health Coaching initiative helped with increasing member compliance in December 2019.



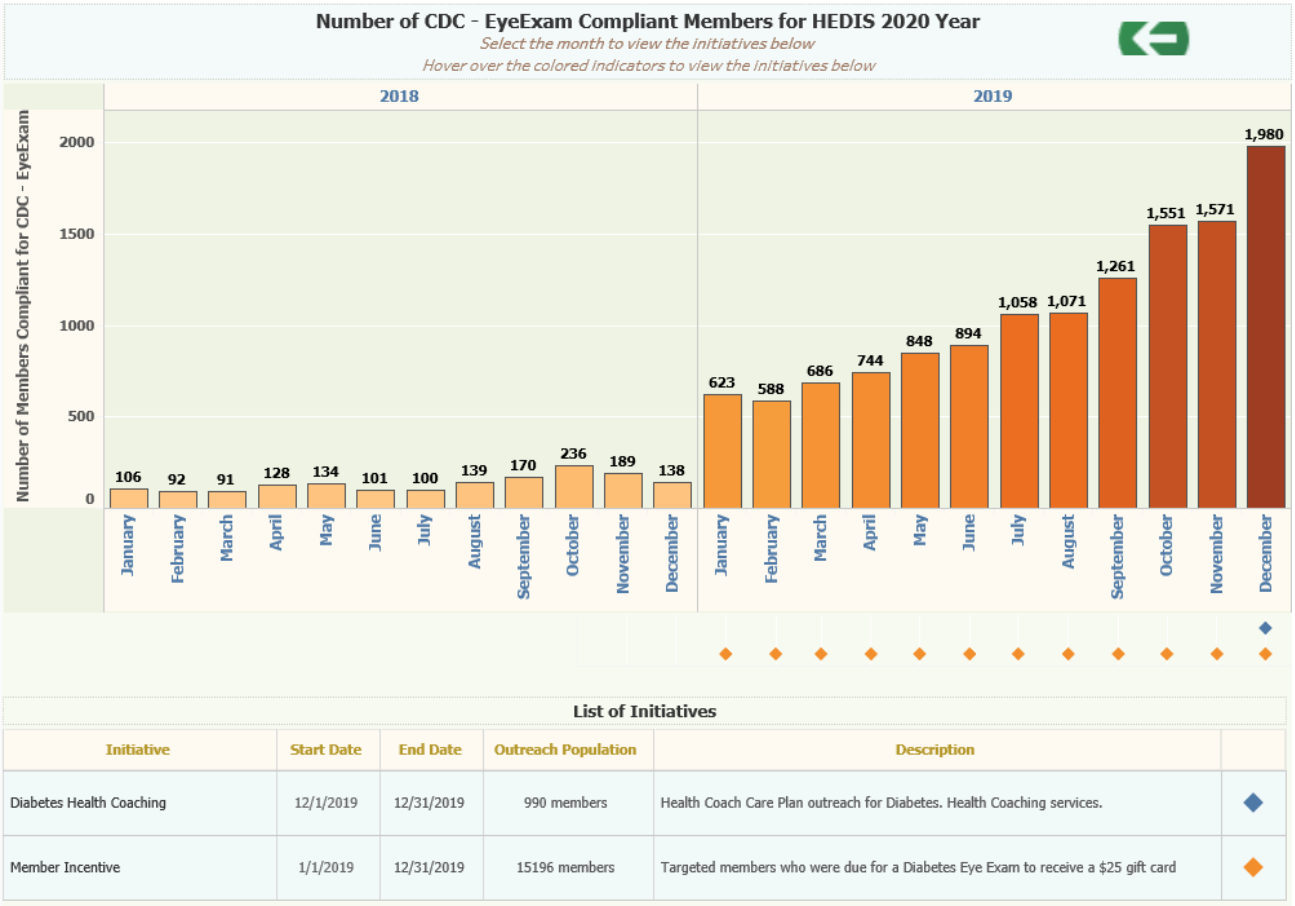
List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description	
A1c IVR campaign	11/1/2019	11/24/2019	29525 members	Outreach to diabetic members via robo calls and encourage them to see their provider	◆
Diabetes Health Coaching	12/1/2019	12/31/2019	990 members	Health Coach Care Plan outreach for Diabetes. Health Coaching services.	◆
Member Incentive	1/1/2019	12/31/2019	15196 members	Targeted members who were due for a HbA1c test to receive a $25 gift card	◆

CDC Table 4-Eye Exam Compliant Members for HEDIS 2020

The table below shows the Eye Exam initiatives for the HEDIS 2020 reporting year. It is split into two sections:

- The 2018 measurement year section contains the number of members that had a negative retinal or dilated eye exam (negative for retinopathy) which would count towards HEDIS 2020 reporting year.
- The 2019 measurement year section contains the numbers of members who had a diabetic retinal eye exam due to a date of service in 2019. The data shows a gradual increase month to month from January 2019 to December 2019. The data shows some increases month to month even more so for June 2019 to October 2019. A factor that could have contributed to this increase may have been the distribution of the member incentive in June 2019. The deployment of the Diabetes Health Coaching initiative also helped with increasing the figure in December 2019.



List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description	
Diabetes Health Coaching	12/1/2019	12/31/2019	990 members	Health Coach Care Plan outreach for Diabetes. Health Coaching services.	◆
Member Incentive	1/1/2019	12/31/2019	15196 members	Targeted members who were due for a Diabetes Eye Exam to receive a $25 gift card	◆

2019 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. **HbA1c IVR Campaign**
   A. **Description:** 55,578 eligible members without an HbA1c completed in the HEDIS 2020 Comprehensive Diabetes Care (CDC) HbA1c testing measure and Medicare LOBs alike were contacted through IVR campaign.

CDC Table 6: IVR calls for All LOBs

2019 A1C IVR Campaign				
LOB	**Successful IVR Calls**	**Unsuccessful IVR Calls**	**Total IVR Calls**	**Rate of successful IVR Calls**
Medi-Cal	17001	35101	52102	32.63%
OC	121	148	269	44.98%
OCC	1033	2174	3207	32.21%

B. Analysis

A successful call is defined as a completed call or message left on voicemail. Overall, there was a 32.63% successful IVR call rate for Medi-Cal. OC had a 44.98% successful IVR call rate. OCC had a 32.21% successful IVR call rate. Members were contacted telephonically via robocall with a message emphasizing the importance of scheduling an HbA1c test with their provider and using statin medication.

C. Barriers

Some barriers include unable to contact member, disconnected phone number, member hung up before the full message was received.

D. Opportunities for Improvement

1. Consider option for text message method for members with mobile cell phone numbers.
2. Increase effort to "clean up" incorrect mobile phone numbers for members.

2. HbA1c and Diabetic Eye Exam Member Incentives

A. Description

Although the diabetes HbA1c Testing and Eye Exam member incentive have been active since 2016, trend analysis of member incentive only included MY2018–MY2019 data due to unavailability of data beyond MY2018.

1. In August 2018, targeted eligible members that were non-compliant in the HEDIS 2019 CDC HbA1c testing (n=10,891) and CDC Eye Exam (n=15,605) measures were mailed both incentive forms for a $15 gift card.
2. In June 2019, targeted eligible members that were non-compliant in the HEDIS 2020 CDC HbA1c testing (n=15,196) and CDC Eye Exam (n=5466) measures were sent the HbA1c Test and/or diabetic eye exam member incentive forms for a $25 gift card. In addition to the member incentive forms, the members also received information on statin medicine and diabetes health coaching services. Population based on March 2019 data pull.

B. Findings

CDC Table 7: MY2018–MY2019 Direct Mail Member Incentive Medi-Cal

Medi-Cal A1C and Eye Exam Member Incentive Mailings						
Measure	**HEDIS Non-Compliant Members Mailed**		**Incentives Received**		**Response Rate**	
	August 2018	**June 2019**	**2018**	**2019**	**2018**	**2019**
HbA1c Test	10,891	15,196	578	510	5.31%	3.36%
Diabetic Eye Exam	15,605	5,466	629	163	4.03%	2.98%

CDC Table 8: MY2018–MY2019 HbA1c Testing and Eye Exam Member Incentive HEDIS Participation Rates

HbA1c Test Incentive Forms	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Incentive Participation Rate
2018	578	546	9,439	5.78%
2019	510	455	12,643	3.59%
Eye Exam Incentive Forms	**Forms Received**	**HEDIS Qualified**	**HEDIS Denominator**	**HEDIS Incentive Participation Rate**
2018	629	593	13,589	4.36%
2019	163	152	4,714	3.22%

C. Analysis

1. In MY2018, of the 10,891 members who were mailed the HbA1c Test incentive, 9,439 remained in the denominator. Of the 578 submitted HbA1c test incentive forms, 546 remained as HEDIS eligible, yielding a 5.78% response rate of HEDIS eligible submissions.
2. In MY2018, of the 15,605 members who were mailed the Eye Exam incentive, 13,589 remained in the HEDIS denominator. Of the 629 submitted Eye Exam incentive forms, 593 remained as HEDIS eligible, yielding a 4.36% response rate of HEDIS eligible submissions.
3. In MY2019, of the 15,196 who were mailed the HbA1c Test incentive, 12,643 remained in the denominator. Of the 510 submitted HbA1ctest incentive forms, 455 remained as HEDIS eligible, yielding a 3.59% response rate of HEDIS eligible submissions.
4. In MY2019, of the 5,466 members who were mailed the Eye Exam incentive, 4,714 remained in the denominator. Of the 163 submitted Eye Exam incentive forms, 152 remained as HEDIS eligible, yielding a 3.22% response rate of HEDIS eligible submissions.

D. Barriers

1. One of the largest barriers for the Eye Exam incentive program was the stall with VSP contracted vision providers permitting members with diabetes to get an annual diabetic eye exam. Although efforts to correct the contract has permitted diabetic members to get their exam on an annual basis — due to a delay in updating the eligibility file that was sent to VSP with a diabetes identifier — CalOptima members were turned away by VSP when in fact members were eligible for the exam.
2. HbA1c test incentive forms regularly came back with the HbA1c value field empty or it was clear members had filled out the form themselves with a blood sugar value reading instead of an HbA1c test value. In addition, a significant number of providers did not complete the retinopathy exam result on the form, often returning the forms with that field blank.
3. In MY2019, due to a data filtering error, only members missing both exams were mailed the incentives rather than members who were missing either the HbA1c test or eye exam. This error was found after the mailing was completed.
4. The target population was not identifiable until after the denominator was pulled usually in March or April of MY, thus causing a regular delay in mailing the incentives.

E. Opportunities for Improvement

1. To promote the importance of annual diabetic eye exams, regardless of whether the member falls into the HEDIS denominator or not, the diabetes incentive mailings will be mailed to all members identified with a diabetes diagnosis.
2. For greater emphasis of compliance with Diabetes HbA1c Testing and Eye Exam, along with all other incentives, there will be concerted effort for greater promotion and marketing of the diabetes member incentives through the HNs, CCN providers and in the community.

2020 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. Emerging Risk Health Coaching Telephonic Outreach

A. Description

To address emerging risk in a timely fashion, eligible members with diabetes who had an HbA1c test result below 8.0% but tested between 8.0% and 9.0% in their most recent HbA1c test were identified for telephone outreach by a health coach to identify quick solutions for returning the HbA1c levels below 8.0%.

B. Findings

CDC Table 9: 2020 Health Coaching Outreach for All Programs: MC, OC and OCC

Year	Qtr	LOB	Starting Denominator	Members assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessful Outreach	Emerging Risk Members Incomplete Assessment	No Longer Eligible
2020	Q1	OC	0	0				
2020	Q1	OCC	4	4	2	0	0	0
2020	Q1	Medi-Cal	148	143	39	5	1	0
2020	**Q1**	**Total**	**152**	**147**	**41**	**5**	**1**	**0**
2020	Q2	OC	8	0	0	0	0	0
2020	Q2	OCC	85	8	6	1	1	0
2020	Q2	Medi-Cal	731	35	22	1	12	0
2020	**Q2**	**Total**	**824**	**43**	**28**	**2**	**13**	**0**

C. Analysis

In Q1 2020, 147 emerging risk members were assigned for telephonic Health Coaching outreach with 41 successful outreach calls. In Q2 2020, 43 emerging risk members were assigned for telephonic Health Coaching outreach and had 28 successful outreach calls.

D. Barriers

Some barriers encountered during the telephonic outreach include being unable to contact the member, unable to coach the member and member opted out/declined telephonic health coaching. In addition, Health Coaches involved in this outreach discovered that the common barriers for members would be homelessness, very limited in terms of food and housing

options and limited transportation/access to care. Another barrier is that health coaches do not get all the questions answered, resulting in incomplete assessments. Health coaches were reminded to try and complete all questions to be able to close out assessments.

E. Opportunities for Improvement

1. Consider outreaching in the next year to members that declined.
2. Stagger the different call attempts at different times to see if member could be reached.
3. Connect homeless members to available homelessness services.
4. Increase awareness of available transportation services to eligible members.

Additional Targeted Diabetes Activities 2020:

- IVR campaign with HbA1c testing and statin medicine messaging for diabetics ran in July 2020 after a deliberate pause due to COVID-19 risk concerns raised by HNs.
- In August, a direct mailing of diabetic eye exam and HbA1c testing member incentives were sent to members who were still outstanding for an annual exam or test. The mailing also contained information on diabetes medication adherence and had a flier for information about the Diabetes Management Health Coaching services. The mailing was originally scheduled for May 2020, however due to the COVID-19 surges, the mailing was delayed and then adjusted to include information about taking precautions when scheduling diabetic exams or care, and for members to discuss the best care plan according to their specific needs.
- Medi-Cal and OCC member newsletter article on the importance of diabetic yearly eye exams, and statin use after a heart attack.
- Collaboration with various HNs on promoting incentive via their call campaign outreach efforts.
- Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
- Ongoing outreach calls to emerging risk population of diabetics who were well controlled, but now have an HbA1c between ≥8.0% and ≤9.0%.
- Ongoing provider fax reports of diabetic members NOT on a statin.
- Ongoing SPD quarterly mailings to educate members with diabetes NOT on a statin on the benefits of statin-use in preventing cardiovascular risk and the importance of having the discussion with their provider.
- Social media message in November 2020 emphasizing the increased for heart disease with diabetes, encouraging members to talk to their doctor about whether a statin may be right for them.

Barriers

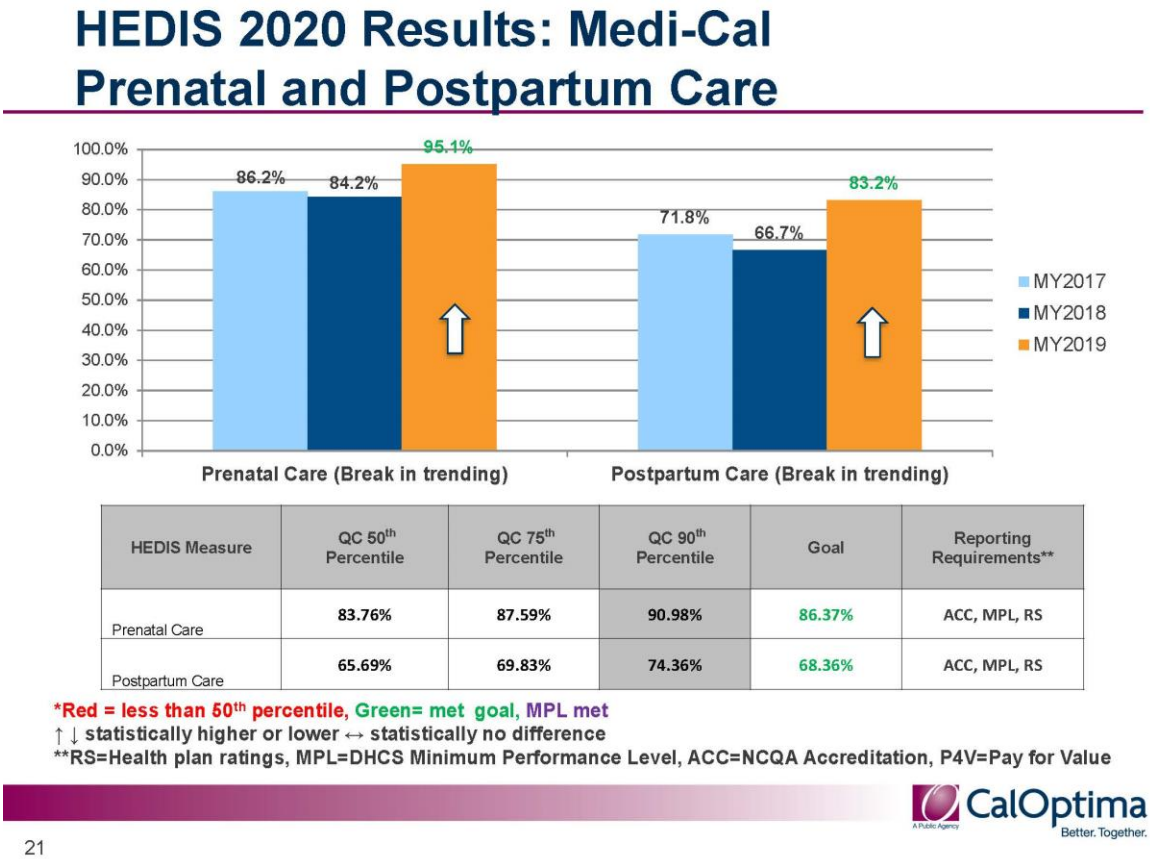
- Members confusion about their benefits related to eye exams. Members who are diabetic are covered to see a vision specialist once every 12 months, but this may not have been communicated clearly to members. CalOptima obtained approval for members to get the service every 12 months with one vendor but this was not translated into the vendor's daily operations for identifying eligible members with diabetes.
- Sharing information between specialists and PCPs sometimes does not occur, thus the PCP may not be aware of previous diabetic eye exam results or the need for an annual diabetic eye exam.
- Limitations in obtaining lab and test data from electronic health records as well as from non-contracted lab vendors.
- Reconciliation of provider data with CalOptima, as some providers use point of care and are not submitting through normal channels.
- Members are not aware of the increased risk of cardiovascular complications with diabetes.

Opportunities for Improvement

- Promote more widely the $25 member incentive program for completion of diabetic eye exams and HbA1c testing to providers through various provider communication modes such as fax blasts, provider portal, HN and provider meetings and through provider relations representatives.
- Explore Office Ally and obtaining electronic health records to improve lab data and access to diabetes medical records.
- Continue targeted call campaign and health coaching intervention for CDC identified members at risk.
- Update VSP eligibility file identification to ensure barrier is removed for annual eye exam for members with diabetes.
- Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
- Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
- Newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Prenatal and Postpartum Care (PPC)

Table 1: PPC HEDIS Rates MY 2017–2019



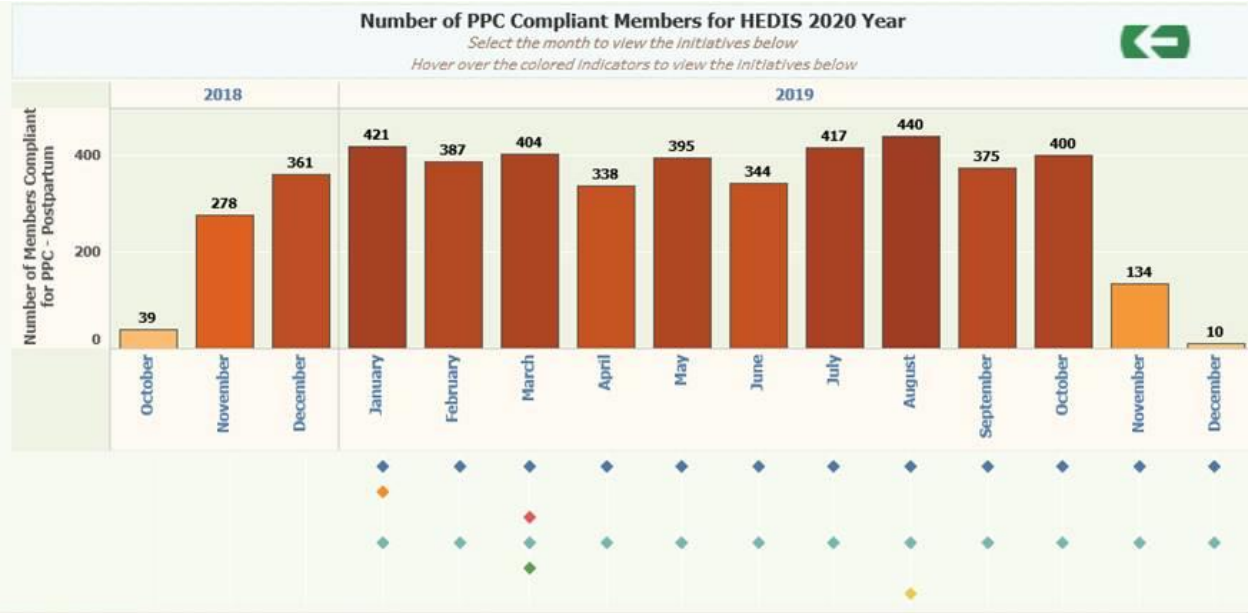
HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	83.76%	87.59%	90.98%	86.37%	ACC, MPL, RS
Postpartum Care	65.69%	69.83%	74.36%	68.36%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

The table above shows a trend analysis for Medi-Cal PPC measure for MY 2017–2019. The rates showed a significant increase from 2018–2019 from the 75th into the 90th percentile for Prenatal Care and from the 50th into the 90th percentile for Postpartum Care. However, it should be noted that this measure had a significant specification change which resulted in most plans nationally seeing a rise in their rates. (Break in trending on the graph above noted for this reason.)

Prenatal and Postpartum Care (PPC) met the 90th percentile, exceeding the MPL.

PPC Table 2: PPC Compliant Members in HEDIS 2020 MY2019



Note:PPC HEDIS 2020 (MY 2019) includes delivery of live births on or between 10/08/2018 and 10/07/2019. PPC HEDIS measure specifications changed from HEDIS 2019 to HEDIS 2020. Postpartum visit date expanded from between 21 and 56 days to between 7 and 84 days.

List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Bright Steps Program	1/1/2019	12/31/2019	2008 members	New Bright Steps program; program for moms and babies. Program includes discussing benefits of postpartum provider follow-up and incentive form during program calls.
Bright Steps Promotion at Breastfeeding Conference	1/29/2019	1/31/2019	N/A	Attended the Breastfeeding conference and tabled for Bright Steps program promotion.
Member Outreach Presentation at CBO	3/1/2019	3/31/2019	N/A	Member presentation (4 total) at Fristers, a CBO that provides service to teen and young adult moms.
Postpartum Checkup Member Incentive Program	1/1/2019	6/30/2019	24 members	$25 target gift card for completing a postpartum visit 3-8 weeks after delivery.
	7/1/2019	12/31/2019	161 members	$50 target gift card for completed postpartum visit 3-8 weeks after delivery.
Spring Medi-Cal Newsletter	3/15/2019	3/22/2019	449967* All MC members	2-page spread about Bright Steps program.
Summer/Fall Medi-Cal Newsletter	8/26/2019	8/28/2019	445214* All MC members	Bight Steps program mentioned in newsletter.

PPC Table 2 data represents all Medi-Cal members with live births between 10/08/2018 and 10/07/2019 that met the continuous enrollment criteria under the HEDIS specifications.

2019 Prenatal and Postpartum Initiatives: Medi-Cal

1. Bright Steps Program (BSP)

A. Description

The Bright Steps Program was launched in September 2018 after MOMS perinatal services ended on August 31, 2018. BSP was offered through December 31, 2018 and successfully outreached to 490 members. Not all these members were part of the HEDIS denominator. In 2019, BSP outreached to 2,008 members. This includes members who are not part of the HEDIS denominator. HEDIS Administrative Data is not reflective of full BSP Outreach efforts. Of those, 631 members in the HEDIS denominator participated in BSP. These members met HEDIS parameters related to live birth timeline and continuous enrollment.

B. Findings

PPC Table 6. BSP Participants — MY2018 and MY2019

HEDIS MY	BSP Participation **Includes Members Non-Compliant with PPC Measure**	HEDIS Denominator	BSP Participation Rate
2018	38	**6965**	<1%
2019	631	**6628**	9.52%

PPC Table 7. PPC Compliance Among Bright Steps Participants

HEDIS MY 2019			
Variables	**Total**	**Denominator (BSP Participants)**	**Rate**
BSP participants compliant with PPC HEDIS measure	473	631	473/631 (74.96%)
BSP participants not compliant with PPC HEDIS measure	158	631	158/631 (25.04%)

C. Analysis

PPC compliance was assessed among all BSP participants.

1. In MY2018, less than 1% of members eligible to participate in BSP participated, but it is not reflective of the program's impact. Low participation rates were due to the timeline of the BSP program launch after perinatal services with MOMs stopped on 8/31/2018. And 63.16% of BSP participants were compliant with the PPC HEDIS measure.
2. In MY2019, 74.96% of BSP participants were compliant with the PPC HEDIS measure. This suggests that BSP participation supports its participants in being compliant with the PPC HEDIS measure.

D. Barriers:

1. Bright Steps outreach may only engage portions of the HEDIS denominator. More widespread outreach may capture a larger portion of the eligible population.
2. BSP outreach is triggered by a pregnancy notification report, thus any failure to notify CalOptima of a pregnancy results in a missed opportunity to reach out to members and offer BSP to support their pregnancy.
3. Members may continue to be unaware of the availability of the BSP and/or the PCIP and are not taking advantage of it.
4. PCIP participation remains low among those that are compliant with the PPC HEDIS measure and complete their postpartum visit within the recommended timeframe. Members continue to be unaware of the availability of the PCIP or may be aware of it and are not taking advantage of it.
5. Comparisons between MY2018 and MY2019 PCIP participation cannot be trended due to the change in value of the health reward that went from $25 to $50.
6. PCIP needs more time to trend MY2020 results to identify its impact of PCIP on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. BSP is still in its early stages. Continue to offer BSP and find ways to augment program participation, such as increasing the accurate submission of PNRs. Continuing BSP will not only continue to provide essential services to mom and baby, but it will allow for trends to assess its impact.
2. Continue promotion efforts of BSP and PCIP among HNs, providers and community organizations.
3. Continue to offer PCIP to BSP participants. It is too soon to trend its impact on PPC HEDIS measure compliance. However, the incentive may also bring about other benefits to mom and their newborn such as financial support during a time that is typically characterized by multiple expenditures.

2. Postpartum Checkup Member Incentive MY2018–2019 6/22/2018–11/2/2018

A. Description

In MY2018, 1,010 eligible pregnant members were identified and mailed postpartum packets containing the PPC member incentive which encouraged members to complete their postpartum visit. These mailings occurred from 6/22/2018 through 11/2/2018. In an internal transition of responsibilities, these postpartum packets were replaced with BSP packets and were made available to members upon request. Mailings of packets were intermittent after November 2018 while the BSP was being resourced and staffed. Processes became more standardized by Q1 2019. In MY2019, 2,008 members were outreached to offer BSP and participating members were mailed BSP packets that contained the postpartum check member incentive.

B. Findings

PPC Table 3. Postpartum Checkup Incentive Submissions MY2018 and MY2019
The tables below show the participation rates and impact on the PPC HEDIS measure across MY2018–2019.

HEDIS MY	PPC Incentive Submissions	PPC Measure Denominator (Total births)	Response Rate
2018	71	6965	**(71/ 6965) 1.02%**
2019	115	6628	**(115/6628) 1.74%**

PPC Table 4: PPC Compliant Members in HEDIS 2019 MY2018

Note: PPC HEDIS 2019 (MY 2018) includes delivery of live births on or between 11/06/2017 and 11/05/2018. Postpartum visit date can occur anytime between 21 and 56 days after delivery.

List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Bright Steps Program	10/1/2018	12/31/2018	490 members	Launch of new Bright Steps program.
MOMS Perinatal Services	Started before 2017	8/31/2018	N/A	MOMs is contracted to provide perinatal services to our Medi-Cal members.
Postpartum Checkup Member Incentive Program	1/1/2018	12/31/2018	82 members	$25 target gift card for completing a postpartum visit 3-8 weeks after delivery.
Postpartum Packet Mailing	6/22/2018	11/2/2018	1010 members	Mailed PPC incentive flier with MEM7 Postpartum Packets
Provider Communication Promoting Bright Steps	10/25/2018	10/25/2018	62 CPSP Providers; 434 Non CPSP Providers	Fax blast to OB providers regarding the launch of Bright Steps, pregnancy notification reports and requirements for CPSP providers.

PPC Table 5. PPC Incentive Submissions by Compliant Members MY2018 and MY2019

HEDIS MY	Members in Compliance with PPC Measure that Participated in PPC Incentive	Total Members in Compliance with PPC Measure	PPC Incentives Submitted By Members Compliant with PPC Measure
2018	56	3954	**(56/3954) 1.41%**
2019	102	4743	**(102/4743) 2.15%**

C. Analysis

1. In MY2019, 71.56% of members were complaint with the PPC measure and received a postpartum visit between 7 and 84 days after delivery. This represents a 14.79% increase in compliance from MY2018. The increase in PPC measure compliance rate is likely due to the expansion of the postpartum measure visit date from between 21 and 56 days in MY2018 to between 7 and 84 days in MY2019.
2. MY2018 PCIP participation rates were low and did not seem to support an increase in PCC measure compliance. While there is an increase in the postpartum checkup incentive program (PCIP) participation in 2019, especially after the health reward value increased

from $25 to $50 in July 2019, there is no suggestion that the increased value of the health reward was the sole reason behind the increased PPC HEDIS measure compliance.

D. Barriers

1. A one-time mailing is not sufficient to alert members of the key importance of postpartum checkup. Low participation rate could be attributed to lack of incentive awareness.
2. In 2019, the date ranges on the incentive form remained at getting a postpartum check at 3–8 weeks postpartum. The form was not updated until February 2020 with the updated date range of 1–12 weeks postpartum.

E. Opportunities for Improvement

1. Continue to promote Bright Steps Program and brand recognition as well as adding of staff.
2. Utilize PPC incentive in a more comprehensive effort to target new mothers to go in for their postpartum check.
3. Continue to incorporate postpartum checkup incentive forms into all Bright Steps maternal packets
4. Implement standard work for trained Bright Steps personal care coordinators to inform members and help schedule postpartum check exams and to take advantage of the incentive offer.
5. Implement a more robust promotion strategy of PPC measure through publicizing the incentive program linked with the Bright Steps program and PPC member incentive to ensure members are aware of the importance of their postpartum checkup.

Additional PPC Activities in 2019

- Tabled and promoted BSP at Breastfeeding Conference in March 2019.
- Presented BSP at Fristers, a community-based organization that provides services to teen and young adult moms.
- PPC incentive program for $25 gift card to Medi-Cal members who complete their postpartum checkup between 3–8 weeks after delivery. It had 24 members that participated in the incentive program.
- PCC incentive program revised in July 2019, increased gift card to $50 to Medi-Cal members who complete their postpartum checkup between 3–8 weeks after delivery. It had 160 members participated in incentive program.
- BSP was able to outreach to 2,008 members providing health education, discussing benefits of postpartum provider follow-up and incentive form during program calls.
- Published two-page spread about BSP in Spring 2019 Medi-Cal newsletter discussing the importance of postpartum care.
- Included BSP promotion in Summer 2019 Medi-Cal newsletter.

2020 Prenatal and Postpartum Initiatives: Medi-Cal

- From January 1, 2020–October 15, 2020, the BSP PCCs made 3,061 attempted outreach calls based on PNRs, self-referrals, HN referrals and internal referrals. Of which, 1,792 initial or postpartum assessments were completed for initial or postpartum (PP) assessments which included a BSP packet sent that included a PPC incentive form.
- All members were outreached to and provided verbal education throughout pregnancy/postpartum and/or provided mailed health education materials that included the postpartum incentive form. Of which, 1,100 postpartum members were called to complete a PP assessment and reminded of the PP visit, over 600 completed the calls and received a PP follow-up reminder verbally by BSP staff.

- The PPC incentive form was updated to represent the longer range between 7 and 84 days postpartum, that the checkup allowed.
- Collaborated with engaged HNs with their call campaign outreach efforts and exchanged data.
- Comprehensive Perinatal Services Program, and an overview of CalOptima's BSP. Also, sent obstetrics providers prenatal/postpartum materials and a BSP prenatal and postpartum care poster.
- Provide HCA Women, Infants, and Children (WIC) sites with BSP prenatal and postpartum care poster to hang in WIC waiting rooms.
- Uploaded the PPC incentive form to CalOptima website for increased member access.

Barriers:
- COVID-19 has become a barrier for prenatal and postpartum care among members.
- A significant number of members that have delivered via c-section have been going in for the wound check visit within the first two weeks and not returning for a postpartum visit between days 21–84 days of delivery.
- Lack of mental health and substance use support in Orange County for pregnant and new moms, which ultimately reduces these members attending prenatal and postpartum visits.
- Providers notifying CalOptima of pregnancies through PNRs. Reduced PNRs results in a missed opportunity to support a member's pregnancy through participation in BSP.
- Teen moms have a barrier in obtaining vaccines during pregnancy because they must get them at their PCP and not their OB. Adding an additional visit, may deter members.

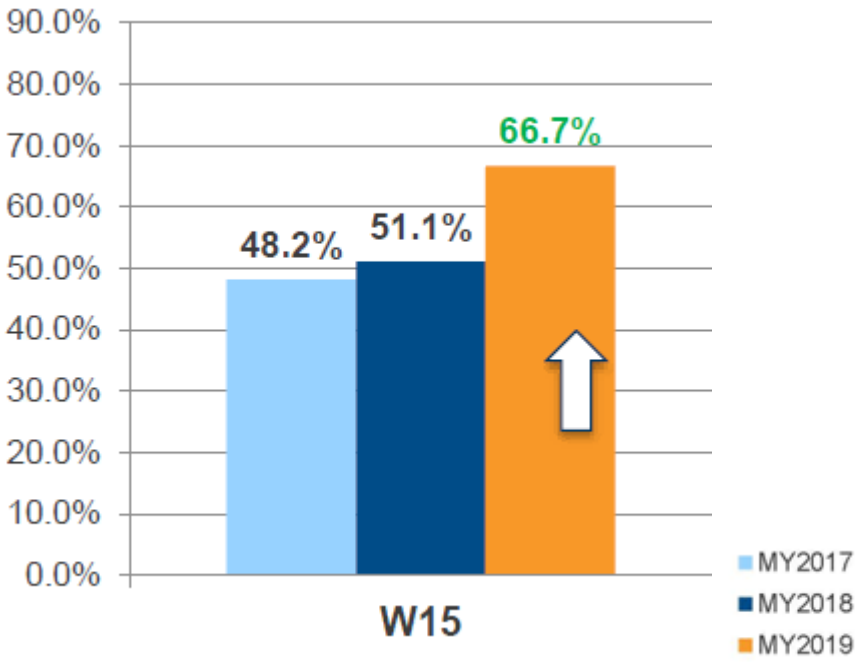
Opportunities for Improvement
- Coordinate promotional campaign to members, providers and community partners for BSP emphasizing the $50 PPC member incentive program.
- Promote CalOptima website and social media platforms with an educational message about women's health and maternal mental health awareness messaging in May 2020.
- Improve collaboration with HNs and CCN providers to promote prenatal and postpartum visits.
- Create a BSP booklet with pregnancy, postpartum and infant information. The booklet will tie in CalOptima benefits and programs.
- Incorporate Adverse Childhood Experiences (ACEs) screening and trauma informed care approach prenatal and postpartum care.

Well-Child Visits in the First 15 Months (W15)

The W15 measure became the top priority initiative in 2019 and 2020, focusing on increasing compliance rates for the W15 measure, which requires the completion of six well-child visits for members from birth to before their 15-month birthday. CalOptima has consistently scored in or below the 50th percentile in 2017 and 2018 and was at risk of not meeting MPL for MCAS requirements which would then lead to potential sanctions and a corrective action plan.

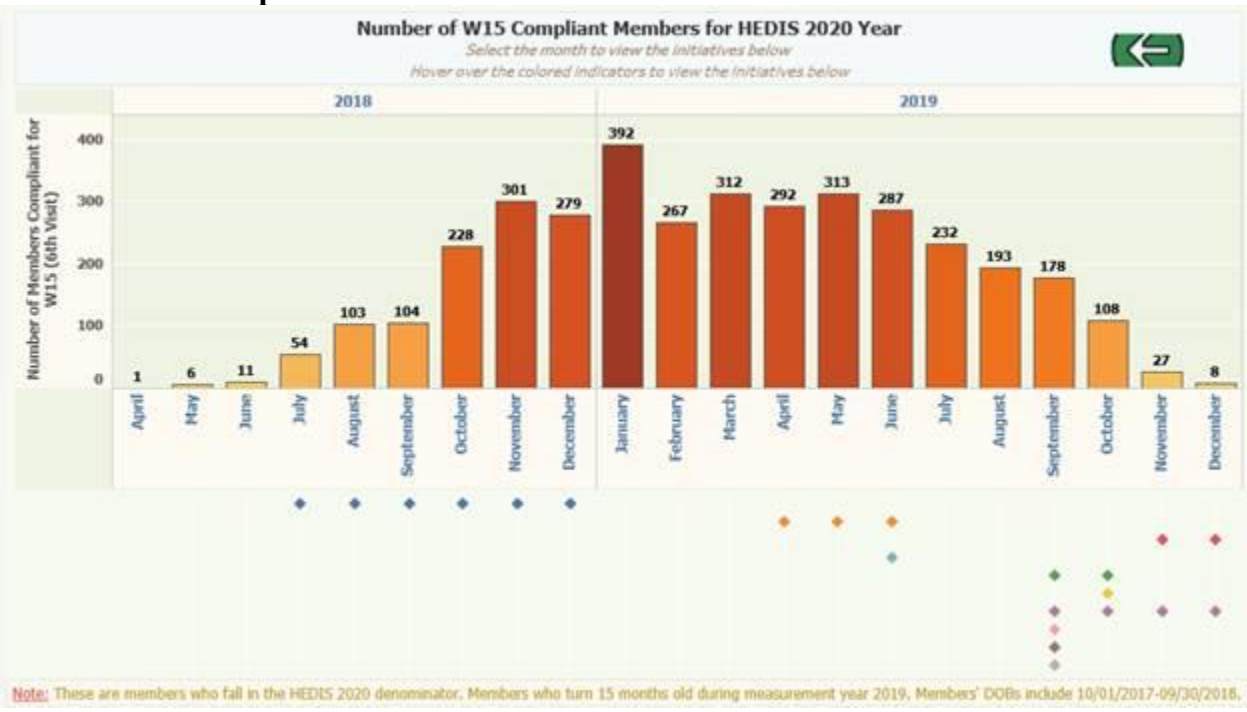
Performance Against Goal:
The table below shows a trend analysis for Medi-Cal W15 rates for MY2017–2019. The rates were consistently below the 50th percentile for two years, however, rates shot above the 50th percentile in MY2019. The W15 measure met the 50th percentile MPL and met goal of 65.83% in MY2019.

W15 Table 1: Number of W15 Compliant Members for HEDIS 2020 Year



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15)	65.83%	69.83%	73.24%	65.83%	MPL, P4V

W15 Table 2: Compliant Members for HEDIS 2020 Year



W15 Table 2 represents all new compliant (six or more visits by 15 months) members by month between April 2018 and December 2019 (n=3696). These members fall in the HEDIS 2020 W15 denominator (N=7765). W15 HEDIS administrative rate is 47.60%. Note, W15 measures members who turn 15 months in the measurement year, however, members age out at different times

throughout 2019. W15 initiatives began in full force in Quarter 3 and 4 of 2019. There was a spike in members identified as completing six well-child visits in January 2019, n=392.

2019 Well-Child Visit in the First 15 Months Initiatives: Medi-Cal

1. CalOptima Day Phase 1 04/17/2019–06/26/2019

A. Description

To address the consistently low performing W15 measure, a concerted campaign to increase the number of W15 visits within compliant timeframe began in April 2019. High volume offices with members who were non-compliant were provided outreach lists to schedule members for CalOptima Day events focused mainly towards W15 and other pediatric well care visits. Members who attended received a $25 gift card and promotional items. Providers received a check of up to $2,400, depending on their tier.

B. Findings

1. There were 11 HNs/provider offices that participated, which yielded 18 child and adolescent events.
2. There were 876 children who participated in CalOptima Days, with 870 were CalOptima Medi-Cal members.
3. Out of 40 of the 870 CalOptima Medi-Cal members who participated in CalOptima Day Phase 1, fell into the MY2019 W15 HEDIS denominator.
4. Attending CalOptima Day event helped impact 22 member's HEDIS numerator count (e.g. visit counted towards Visit 3, Visit 4, Visit 5).
    - With 7 members that became compliant on the CalOptima Day event.
5. Of which, 22 of these 40 members are compliant for W15 by end of measurement year.

C. Analysis

1. Assumptions: Membership (denominators) for clinics are fluid throughout the measurement year due to members losing eligibility, regaining eligibility—e.g. HEDIS technical specifications has an allowable enrollment gap of 45 days, or being completely terminated.
2. Unable to correlate if attending a CalOptima Day is the reason why a member became compliant for W15 since it requires a series of well-care visits but can assume it contributed to a visit numerator hit.
3. Based on claims and encounters received through August 2019, 35 W15 members had a DOS on CalOptima Event Date. Of those, the data showed the member's visit complied with W15 and/or CIS measure. Even though the events did not outreach to many W15 members, the ones who did come in impacted the following measures:
    - CIS only: 1 member
    - CIS + W15: 10 members
    - W15 only: 24 members

D. Barriers

1. Scheduling challenges and inconsistencies in information relayed to members for CalOptima Day resulted in member confusion and delay of gift card assignment.
2. Provider offices had limited resources to call the members on the outreach lists, which required offices to reconcile with their internal records for most updated contact information, eligibility, and measure compliance.
3. Exchange of outreach lists and schedules were difficult as some offices did not have an established secure email portal or could not get access to Cisco.

4. Reminder letters required a lot of administrative work and had to be completed in a short timeframe. Letters did not seem to generate a high yield of responses.
5. CalOptima's data is not up to date with claims lag.

E. Opportunities for Improvement

1. Stop offering to send outreach lists to participating PCP offices in the future since CalOptima's data is not up to date with claims lag.
2. Do not send reminder letters to members who are scheduled for CalOptima Days as it is resource intensive with low yield. Provider offices tend to have their own method of appointment reminder (e.g. text or phone call day prior).
3. Establish roles and responsibilities in the planning stages of CalOptima Day to understand who can be contacted for deliverables and who will be available on-site on event day.
4. Focus on a targeted HEDIS measure with a smaller population to increase probability of increase HEDIS rate.
5. Do not provide or promote promotional items.
6. Do not require CalOptima to table the event or sign out gift cards. Remove member incentive all together to eliminate administrative accountability.
7. Discuss with participating offices appropriate coding and best billing practices. Incorporate a requirement for immediate claim and encounter submission as part of the provider incentive.

2. W15-Only CalOptima Days 11/19/2019–12/19/2019

A. Description

In an effort to refocus on scheduling only W15 visits and move away from other pediatric or piloted adult well care visits, 4 clinic sites participated in W15-only CalOptima Days in Q4 2019. A total of seven CalOptima Day events occurred, as each site could host more than one event in the same week.

- Strong Kids Medical Group
- Pediatrics & Neonatology
- South Coast Pediatrics
- Friends of Family Health Center

1. Provider offices outreached to any members ages 0–15 months old. Patients had to be a CalOptima Medi-Cal member.
2. Unlike previous CalOptima Days, outreach lists were not provided to the office.
3. Event day schedule lists and final HEDIS 2020 Rates used to evaluate.
4. Provider offices received an incentive for hosting CalOptima Day.
5. No member incentive was provided for this series of CalOptima Days.

B. Findings

1. Only 24 of the 129 members who participated in the W15-Only CalOptima Day fell into the MY2019 W15 HEDIS denominator.
2. Attending W15-only CalOptima Day event helped impact two member's HEDIS numerator count.
3. One member became compliant on the CalOptima Day event.
4. Of which, 11 of these 24 members were compliant for W15 by end of MY.

W15 Table 3: W15 CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed HEDIS Eligible Members
South Coast Pediatrics	66	52	78.79%	44
South Coast Pediatrics	4	3	75.00%	2
South Coast Pediatrics	16	15	93.75%	15
Pediatrics and Neonatology	47	34	72.34%	34
Strong Families Santa Ana	21	14	66.67%	14
Friends of Family (Tustin)	6	4	66.67%	1
Friends of Family (LH)	63	31	49.21%	19

C. Analysis

1. Offices were able to outreach and identify their 0–15 months population without needing CalOptima's administrative help.
2. Average attendance rate was 71.77% which was higher than the CalOptima Days Event in Q2 2019 (67.17%).
3. Final HEDIS 2020 W15 Admin Rate was 47.60% (excluding Kaiser members).
4. Impact to administrative rate: 0.013% (1/7765). Overall, the CalOptima Day Events did not impact the HEDIS population as desired, as a small percentage of those who attended impacted the administrative rate.

D. Barriers

1. In an effort to ease the scheduling process, the offices were able to outreach to *any* Medi-Cal member that falls into the 0–15 months age range, therefore member visits may not have been included toward the W15 HEDIS 2020 rate due to specific eligibility requirements.
2. The CalOptima Day events in Q4 2019 were a year-end effort to improve W15 rate, so all six visits may not have been able to be scheduled and completed before the end of the calendar year.
3. There's inaccuracy in relying on the offices to know which visit in the series of six the member was coming in for.
4. Offices schedule members for the well-child visits at different age increments, not necessarily in compliance to the 6 visits *before* 15 months that HEDIS specifications stipulate.
5. It was difficult to conclude that CalOptima Days made a significant impact on the overall increase in W15 rates versus other simultaneous intervention efforts, including supplemental encounter and data capture, educational campaigns and the member and provider W15 incentives.
6. Total of $8,000 in provider incentives was spent on these CalOptima Days. The return on investment (ROI) was low; the impact on W15 HEDIS rate was 0.013%.
7. CalOptima Days were a good avenue to engage and educate the provider offices on the effort to improve well-child visit rates. The coordination provided an avenue to correct

certain provider office well-child schedules and to provide an exchange of data and a closer look at their data.

8. Future proactive provider engagement regarding data should be pursued considering W15 is a P4V measure and there seemed to be confusion on measure expectations.

E. Opportunities for Improvement

1. Discontinue CalOptima Days due to the significant amount of staff time and resources required to coordinate, execute and follow up with member and provider incentive payouts

3. Health Guide 0–2 Newsletter 06/21/2019

A. Description

Health Guide 0–2 newsletter mail dropped on 06/21/2019 and targeted 10,991 Medi-Cal members ages 0–2 years old and fell into the CIS and W15 denominator, using March 2019 prospective rate (PR) data to filter mailing list. For the evaluation please see the HEDIS 2020 Final Rates.

B. Findings

1. The Health Guide 0–2 newsletter was mailed to 6510 members in the W15 HEDIS denominator .
2. After receiving the mailing, 830 of the 6510 members completed their 6th well-child.
3. By end of MY, 2,848 of the 6510 members were complaint for W15.
4. Participation by 160 of the 6510 members in the W15 4-6 incentive program. Of which 132 of the 160 members were compliant for W15.

C. Analysis

1. Even though 830 members completed their sixth well-child visit and became complaint ***after*** receiving the Health Guide 0–2 mailing, we cannot correlate the mailing as the reason they visited their provider. Members may have had other outreaches/touchpoints. The Health Guide 0–2 mailing occurred midyear in June, before the incentive was launched in September.
2. The newsletter mailing project (including postage) cost $13,714.43. If the mailing was the reason members visited their providers, the cost was approximately $16.52 ($13,714.43/830) per member for each HEDIS hit.

D. Barriers:

1. Health Guide 0–2 newsletter only included member health education regarding well-child visits and vaccinations. No well-child visit incentive form was included.
2. No direct correlation between receipt of the health guide and the child's visit to the provider.

E. Opportunities for Improvement

1. Make the Health Guide available online and promote the newsletter through other avenues (e.g. Community Connections).
2. Use Health Guides as supplemental education source if members need it.
3. Stop Health Guide mailing.

4. Well-Child Visits 4–6 Member Incentive 09/01/2019–12/31/2019, and Targeted Mailing 09/03/2019

A. Description

Medi-Cal CalOptima members ages 0–15 months are eligible for Well-Child Visits 4–6 incentive if they complete six well-child visits before turning 15 months old. The form must be completed by their provider and faxed in within 60 days of the sixth DOS. The incentive program launched 9/1/2019 and ran through 12/31/2019. An updated incentive form launched 1/1/2020. A targeted mailing was dropped on 09/03/2020 as a concerted effort to reach out to members who were due for W15. Mailing quantity: 1627, based on June provider relations data. The following evaluation is data is from PHM Incentives Database and final HEDIS 2020 rates.

B. Findings

1. The incentive mailing was sent to 1299 W15 members in the denominator.
2. Of which, 821 of these 1299 W15 members were compliant for W15 by end of measurement year.
3. Total incentive forms received: 276
4. Total qualifying for HEDIS (fell in the W15 denominator): 176
5. Actual members compliant for HEDIS: 145

C. Analysis

1. In 2019, of 276 W15 incentive forms received, 176 members were in the W15 measure denominator. The incentive participation rate for the HEDIS 2020 W15 measures was 10.82% (176/1627). Of the 176 submitted forms there were 47 forms (26.74%) had a sixth visit DOS that matched our claims/encounters data that fit all Quality Spectrum Insight (QSI) HEDIS criteria.
2. Of the 1627 members that were targeted, 1299 were in the denominator for the HEDIS 2020 W15 measure. Of those who were mailed the incentive, 666 completed their sixth well-child visit after the mailing.
3. Targeted mailing is not an effective way of getting members to come in for their well-child visits. Only 97 of the 666 members who were W15 compliant and received the outreach mailing, completed their sixth visit and received the incentive. Only 14.56% of members took advantage of the incentive program.

D. Barriers

1. W15 age group is 0–15 months old, however only those turning 15 months old in the measurement year technically falls into the HEDIS measure. So those who are too young, may have completed six visits but are not counted toward W15 denominator until the year after.
2. Since the submissions are not bumped up against claims and encounters, the sixth DOS is not validated. Incentive form was taken at face value.
3. Anecdotal qualitative data showed that in clarification inquiries with various provider offices, certain members were unable to complete their sixth W15 visit before their 15 month birthday, because providers were routinely scheduling members after the member turned 15 months.
4. Unable to correlate if the targeted mailing is the reason member completed the well-child visit series.

E. Opportunities for Improvement

1. This incentive was a pilot program. Will continue as planned and launch Well-Child Visits 1–3 and Well-Child Visits 4–6 incentives.
2. Will bump up submissions against claims and encounters data for 2020 submissions for provider payment. There will be leniency for the member since the provider is attesting to the form.
3. Provide clearer instructions of the measure requirements of when the sixth visit is to be completed.
4. Do not do targeted mailings in the future, rather disseminate incentive program through PCPs.

5. Well-Child Visits 4–6 Provider Incentive Program 09/01/2019–12/31/2019

A. Description

Provider outreach was conducted via fax blast (273 providers), twice. Information was disseminated to HNs through email communications and various network relations meetings and monthly quality meetings. If incentive form was submitted timely and met all incentive criteria, then provider incentive was approved. Did not validate submission (sixth DOS) against claims and encounters data.

B. Findings

1. 49 unique providers participated in the W15 4–6 inventive program pilot
2. Q4 2019 breakdown:
   - Total submissions: 306
   - Total approved: 191
   - Total denied: 115
   - Total incentive: $9,550

W15 Table 4. Well-Child Visits 4–6 Provider Incentive Summary

Incentive Program	Total Submissions	Total Approved	Total Denied	Total Incentive
W15 4–6 Provider	**306**	**191**	**115**	**$9,550**

C. Analysis

1. Approved 191 submissions for provider incentive. However, only 176 members who participated in the incentive program fell into the W15 denominator.
2. An incentive sent to 49 providers for participating in the Well-Child 4–6 Visits provider incentive program. Total payout for Q4 2019 was $9,550. *Note: a few Q1 2020 was accidentally processed along with this batch.*

D. Barriers

1. Incentive forms were taken at face value and DOS were not validated against claims and encounters data.
2. It is probable that more sixth DOS are accurate and claims and encounters were received, but member or visit did not meet all W15 HEDIS specifications to be a numerator hit in QSI.

E. Opportunities for Improvement

1. Revise W15 4–6 incentive form and promote the incentive parameters clearer.

2. Try to touch base with provider offices as incentives are received and processed so there can be education real time to prevent same mistakes moving forward.
3. Bump up submissions against claims and encounters data to validate DOS. Even though incentive parameters were strictly enforced for providers, per the Final HEDIS 2020 rates we learned that most of the incentives submitted were not accurate despite promoting the incentive form as an "attestation."

6. Well-Child W15 Call Campaign 09/13/2019–10/04/2019

A. Description

The W15 call campaign was conducted between 09/13/2019–10/04/2019 targeting members who have an opportunity to complete six well-child visits before turning 15 months old and to promote the Well-Child 4–6 Visits member incentive based on June W15 2019 provider relations data.

B. Findings

1. There were 574 of the 724 members outreached for the Well-Child Call Campaign that fell in the W15 denominator.
2. Of which 471 of the 574 members in the HEDIS denominator were successfully outreached, meaning there was a live phone call with the member or a complete voicemail left regarding well-child visits.

W15 Table 5. Well-Child Call Campaign Summary

	Successful W15 Call	Unsuccessful W15 Call	Total Calls	Rate of Successful Calls
Call Campaign Members Identified	**568**	**156**	**724**	**78.45%**
HEDIS 2020 W15 Denominator	**471**	**103**	**574**	**82.06%**

C. Analysis

1. Had 150 members who were a part of the W15 call campaign fall out of the W15 denominator or was a Kaiser member.
2. Calls to 65.06% (471/724) was successfully outreached to a W15 member.
3. With 361 of the 471 members were compliant for W15 by end of MY.
4. Of which 59 of the 471 members completed their sixth well-child visit after receiving the telephonic outreach. Impact to W15 HEDIS rate was 0.76%. Note, we assume the 59 members completed their sixth visit due to the outreach call.
5. And 12 members who were successfully outreached telephonically, completed their sixth well-child visit after outreach call and submitted an incentive form.

D. Barriers

1. The outreach list was limited to members who were identified as being able to complete six well-child visits, which meets CalOptima's goal of improving our W15 rate.
2. Anecdote from member's parents or guardian:
   - Did not receive the targeted mailing; had to re-mail incentive form.
   - Was not aware they needed to complete six well-child visits before 15th month birthday.
   - Did not know which visits the child had completed.

E. Opportunities for Improvement

1. Recommend a targeted call campaign again in the future to help increase HEDIS rate.
2. Conduct the calls more periodically throughout the year verses one time at the end of the year will minimize members left — who have not aged out — to impact the rate.
3. Prepare a targeted outreach list as a standard work to sustain high successful call rate 82.06%.

7. W15 Root Cause Analysis Survey Incentive 10/10/2019–10/31/2019

A. Methodology/Data

In an effort to identify reasons why the first and second visits were difficult to find data for, an internal Initial Health Assessment (IHA) Core Report was utilized to identify members with a Date of Birth = June 2019 who showed as having completed an initial health visit. The rationale was to identify members who likely did go in for a W15 first or second visit within the first three months of life, but which had not been submitted as a claim or as a well-child-visit encounter administratively. Health educators were provided a survey and script which asked parents where they took their newborns for their first well-child visit post-delivery. The member was offered a $15 gift card for participating in the telephonic survey.

B. Findings

1. Call attempts were made to 94 members.
2. Parent or guardian may have provided more than one well-child visit in the first three months of life.
3. Data is based on QSI prospective rates, well-child visits claims/encounters received and processed as of November 2019.
4. Of which 22 of the 31 members surveyed had a well-child visit claims/encounters in the first there months of life.

C. Analysis

1. There was 70.97% (22/31) of members that had a well-child visit in the first three months of life.
2. There had been 22 newborns with at least one well-child visit in the first three months of life.
   - 29.63% had a well-child visit between birth–2 weeks old
   - 7.41% had a well-child visit at 1 month old
   - 33.33% had a well-child visit at 2 months old
   - 14.81% had a well-child visit at 3 months old

D. Barriers

- Parents did not know the exact date or provider name who completed the well-child visit.
- Parents needed education to differentiate between a sick visit and well-child visit.
- CalOptima does not have data on these well-child visits, even though the calls were made when a child was three months old. There is a data gap.

E. Opportunities for Improvement

- Work with HEDIS team to map out logic to better identify well-child visits administratively.

Additional W15 Activities in 2019

- 2019 Medi-Cal newsletter highlighted the *Don't Forget to Vaccinate, Get Shots at No Cost* article discussing the importance of well-care visits, immunization requirements for kindergarten and information on measles.

2020 Well-Child Visits Before 15 Months Initiatives: Medi-Cal

1. CHOC Health Alliance (CHA) CalOptima Day 03/04/2020–03/05/2020

A. Methodology/Data

CalOptima Day was planned for Q4 2019 with the other W15 only events, however the event was moved to March 2020. CHOC Health Alliance dedicated two sites for CalOptima Day and focused on members who are due for W15, W34, or AWC.

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments scheduled, 103 attended and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments scheduled, 64 attended and 45 confirmed CalOptima Medi-Cal members.

W15 Table 6. CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed CalOptima Medi-Cal Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. Total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance had a high attendance rate 78.05%–90.35%

D. Barriers

1. Difficulty communicating with CHOC Health Alliance. Had to go through a mediator to get the event going.
2. There was a change in staff which led to delays.
3. Office manager requested to include more members because they were unable to schedule W15 only members. Decision to allow CHA to open their schedule for W15, W34 and AWC members.
4. Post event it was difficult to get the schedule list from the sites to confirm the visits.
5. It was helpful to remove administrative burden on CalOptima to provide outreach lists and send reminder letters. However, without the proper champions on-site it made it difficult.

E. Opportunities for Improvement

1. Discontinue CalOptima Days for the W15 initiative.
2. Encourage designation of a proper champions on-site to continue member outreach.

2. Well-Child Visits 1–3 and 4–6 Member and Provider Incentive 01/01/2020–current

A. Description: Continue the first full year of W15 incentives.

1. Well-Child Visits 1–3: CalOptima Medi-Cal members ages 0–6 months old who complete at least three well-child visits by six months of age qualify for $50 gift card incentive.
2. Well-Child Visits 4-6: CalOptima Medi-Cal members ages 0-15 months old who complete at least six well-child visits before 15 months of age qualify for $50 gift card incentive.
3. Provider was incentivized $50 incentive for every eligible member submission. Well-Child Visit DOS for third and sixth visit will be validated through claims and encounters data.

B. Findings

1. PHM Incentive Database, as of 10/7/20:
   - Well-Child Visits 1–3
     - 1,073 records have been processed
       - 970 records have been approved = $48,500
       - 91 records have been denied
       - 12 records are pending
   - Well-Child Visits 4–6
     - 532 records have been processed
       - 480 records have been approved = $24,000
       - 42 records have been denied
       - 10 records are pending

W15 Table 7. Well-Child Incentive Program Response Rates as on 10/07/20

Incentive Program	HEDIS MY2020 W15 Population	Number of Submissions	Response Rate
W15 1-3	8752	1073	12.26%
W15 4-6	8752	533	6.09%

C. Barriers and Analysis

1. There are more W15 1–3 visit completed submissions than the W15 4–6 visit submissions. The way the incentives were split contributes to a failure to emphasize the need for six visits before 15 months. While the purpose of splitting the W15 incentive in to two parts was to motivate parents at the mid-point to complete W15 4–6 that is not what the preliminary results show. The way the incentives are split, there is no way to determine which visits in the series the dates of service point to. W15 1–3 incentive has approximately 50.33% more submissions than W15 4–6 incentive. The completion of six visits before 15 months is difficult to do due to the lack of continuity with one provider, or non-HEDIS compliant schedule being applied to schedule visits. There is an obvious continued drop off of the fifth and sixth visits.

2. Prospective rates show the rates for W15 1–4 visits are doing better in MY2020 over last year. Visits five and six are behind 9% but are starting to trend in a positive direction. However, a separate evaluation is yet to be completed to see how greater supplemental data and encounters may be the greatest factor, in higher rates.
3. It appears that provider offices are not using the incentive to drive historical non-utilizers to come in for visits, but rather providers are utilizing the incentives to reinforce completed utilization and capitalize on the extra income source for both themselves and members during this unique 2020 year.
4. While most providers seem to follow the Bright Steps well-child visit guidance, discussions with several offices provide evidence that some providers skip the one month old and nine-month-old follow up visit because there is no vaccination required. Offices tend to align their well-child visits with the vaccination schedule. The incentive program has created opportunity to educate participating provider offices on HEDIS expectations and how modifications can be made to well-child visit scheduling to meet measurement standards.
5. Provider office must submit claims and encounters for visit in order for this incentive to be measurable and effective.
6. The W15 incentive in its current format has limitations due to good provider involvement and positive member experience in light of COVID-19. The W15 incentive will continue until a new well care general incentive is discussed and developed to promote overall well care visits especially as the W15 measure is being combined into a Well-Child Visits in the First 30 Months (W30) combined measure, extending the age range from 0–30 months.

D. Opportunities for Improvement

1. Sunset the W15 member and provider incentives at the end of 2020 calendar year due to fiscal constraints and depletion of budgeted funds.
2. Preliminary evaluation shows that most member incentives submitted only reflected three visits, and a smaller portion of submissions were for all six visits completed before the 15 month birthday. This suggests that the incentives are not used to motivate utilization as intentioned.
3. The W15 measure is being combined into a Well-Child Visits in the First 30 Months (W30) combined measure, extending the age range from 0–30 months.
4. Notify HNs and providers that the W15 incentive is ending at the end of 2020 calendar year.

Additional W15 Activities in 2020

- **Health Guide 0–2 newsletter and W15 incentive mailing** dropped 07/24/2020 to 8,960 members ages 0–12 months old in English, Spanish and Vietnamese. Members 0–6 months old received W15 1–3 and W15 4–6 incentive form = 3,894. Members 7–12 months old received W15 4–6 incentive form = 5,066
- ***Well-Child Visits During COVID-19 Pandemic*** article in the May Provider Update discussed the importance of continuing well-child visits during the pandemic in accordance with AAP guidelines. Care for newborns and well visit and immunizations of infants and young children (through 24 months of age) were prioritized.
- ***2020 CalOptima Member and Provider Incentive Programs*** article in the July Provider Update. Article discussed CalOptima's PHM incentive opportunities, clarified incentive eligibility requirements, and reiterated the W15 member and provider incentive criteria.
- ***Well-Care Visits and Vaccinations During a Pandemic*** in the Orange County Immunization Coalition (OCIC) Summer newsletter.

- **Post Bright Steps Well Baby Follow-Up Call Project in September 2020.** After a mother graduated from the BSP by completing the Postpartum Assessment, the Bright Steps team created an activity to follow-up with the baby in either two weeks or when baby was three months old depending on their risk level. In the first month, 82 members were identified in the queue for telephone outreach for W15 well-child visits and vaccinations.

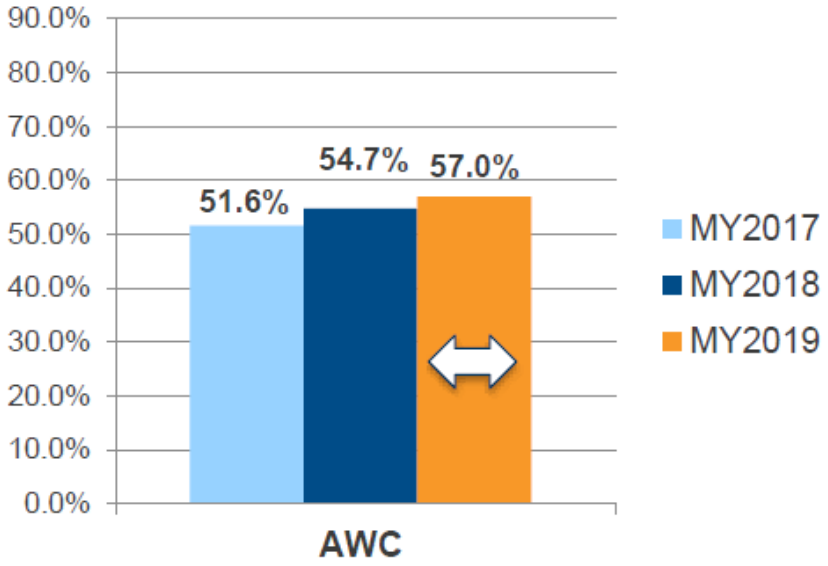
Opportunities for Improvement:

- Conduct a formal evaluation of how data gaps can be closed, since the W15 measure is changing into the W30 measure and will be strictly an administrative measure, no longer allowing for medical record review.
- Research on how to gain access to high volume provider offices' EMR system in order to locate member visit information more efficiently whether through Office Ally or other avenues.
- Develop crosswalk to identify potential member visits recorded under mother's CIN.
- Promote well-child visits through Bright Steps prenatal and postpartum calls through Post Bright Steps Well Baby Follow Up Call Project.
- Continue to incentivize well-child visits to providers in the 2021 P4V program, while exploring alternative member health reward options

Adolescent Well-Care Visits (AWC)

The table below shows a trend analysis for Medi-Cal HEDIS AWC for the MY2017–2019. The rates have steadily increased for AWC the past three years. However, a decline is anticipated in the 2020 MY rates due to observed dip in preventive care and well care visits during the COVID-19 pandemic.

AWC Table 1: MY2017–2019 Results: Medi-Cal
The rate for AWC is presented below, AWC met the 50th MPL at 57.0%, but did not meet the goal of 60.34%.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Adolescent Well-Care Visits (AWC)	54.26%	62.77%	68.14%	60.34%	MPL, P4V

2019 Adolescent Well-Care Initiatives: Medi-Cal

1. CalOptima Day Phase 1 04/17/2019–06/26/2019

A. Description

In an effort to impact adolescent well care visits, March, April and May 2019 prospective rates were pulled to provide offices with outreach lists to schedule members for CalOptima Day event.

B. Findings

1. A total of 18 CalOptima events focused on adolescent well-care visits. These events were held at 11 different clinic sites throughout Orange County.
2. The events yielded a potential of 625 HEDIS hits across the five pediatric HEDIS measures.
3. Based on the July 2019 prospective rates, 546 members fell into the AWC denominator, which yielded a potential of 373 potential hits for the AWC measure.

AWC Table 1. Measuring AWC rate improvement between July 2018 prospective rate and July 2019 prospective rate for CalOptima Day Participating Provider Offices

PROVIDER OFFICE NAME	AWC Rate Improvement
CHOC Orange Clinic	-4.84%
CLINICA CHOC Para Ninos	-2.66%
Gateway Medical Group*	-11.76%
Pediatrics & Neonatology	3.10%
San Juan Pediatrics	-1.84%
South Coast Pediatrics	-4.99%
StrongKids Medical Group**	5.43%
UCI FHC — Anaheim	3.35%
UCI FHC — Santa Ana	1.92%

* Gateway Medical Group events held at two different sites since members can be seen at either.
** StrongKids Medical Group events held at two different sites since members can be seen at either.

C. Analysis

1. There were 373/625 = 59.68% of the potential HEDIS hits for AWC.
2. On AWC Table 1, the majority of the clinics did not have an AWC rate improvement. However, AWC has the largest population out of the pediatric measures listed above, which allowed for an easier scheduling, but to impact rates it is more difficult.
3. The AWC denominator was too large to impact with limited events such as CalOptima Day. With many resources required, CalOptima Days are not recommended to try and impact the AWC measure. CalOptima Days should be limited to a very targeted HEDIS measure with a population (denominator) that is large enough for ease of scheduling but small enough to make a sizable impact on the rate.

D. Barriers

1. Scheduling was challenging for offices to get members in on the same day. No show rates were high.
2. Clinic administration buy-in was important. Clinics with a champion for this event tend to have a better outcome.
3. Learning curves during the planning stage of program.

E. Opportunities for Improvement

1. Stop CalOptima Days to impact the AWC measure.
2. Limit CalOptima Days to a very targeted HEDIS measure with a population (denominator) that is large enough for ease of scheduling but small enough to make a sizable impact on the rate.

2020 Adolescent Well-Care Initiatives: Medi-Cal

1. Annual Well-Care Visits 12–17 (AWC) Member Incentive Program 01/01/2020–current; and Health Guide 13–17 Newsletter Mailing with AWC Incentive Form 05/28/2020

A. Description

An AWC incentive was created to motivate an increase in AWC visits for all eligible Medi-Cal CalOptima members ages 12–17 years old. Requirement was to complete annual well-care visit and submit for a $25 gift card or three movie tickets. The incentive was mailed along with the Health Guide 13–17 newsletter on 05/28/2020 to 74,651 members who were identified as noncompliant for AWC based on February 2020 PR.

B. Findings

As of 10/15/20:

1. 8,301 AWC incentive forms have been processed
   - 6,771 AWC incentive forms have been approved = ~$169,275
   - 541 AWC incentive forms have been denied
   - 989 AWC incentive forms are pending
2. 224 members who submitted an AWC incentive form were a part of the Health Guide 13–17 newsletter and AWC Incentive Form mailing back in 5/28/20.

AWC Table 2. Annual Well Care Visits 12–17 Incentive Response Rate as of 10/15/20

Incentive Program	HEDIS MY2020 AWC Population	Total Incentive Submissions	Response Rate Based on Total AWC Population
AWC	**149,177**	**8,301**	**5.56%**

C. Analysis:

1. An unexpected large surge of incentives were submitted for the AWC incentive. Suspected reasons include the COVID-19 pandemic, in which medical office staff utilized available time to check on AWC visits already completed in 2020, to submit on behalf of members, during a time of financial insecurity. Instead of promoting utilization from historical non-compliant members, the COVID-19 climate ended up boosting incentive submissions due to the unique circumstances described above.
2. Approximately $169,275 was spent on AWC incentive. With a response rate of 5.56% the impact on HEDIS (if all submissions are accurate and claims are submitted correctly) will still remain minor due to the large denominator of 149,177.

3. Response rate for those included in the targeting mailing was 0.30% (224/74651).
4. For MY2020, the AWC HEDIS measure were revised into the Child and Adolescent Well-Care Visits (WCV) measure which combined the W34 and AWC measures and added the ages 7–11 years.

D. Barriers

1. Recommendation for members to complete their annual well-care visit changed in March 2020 due to the COVID-19 pandemic. There was a period where adolescent annual well-care visits were not being scheduled as advised by the CDC. CalOptima's June 2020 Prospective rate reports show a decline when compared to the same time last year. June 2020 AWC PR 14.65%, June 2019 AWC PR 18.81%; declined 4.16% compared to last year.
2. Providers did not always use the right CPT code, or did not clearly distinguish between a sports physical exam and a comprehensive well-care visit.
3. Difficult to move the needle with such a large population like AWC.
4. Providers are not using AWC incentive as intended. Where the incentive was designed to motivate and promote future utilization by historical non-compliant members, providers were filling out the incentive form on the member's behalf and submitting it to CalOptima without the member's knowledge and requested that CalOptima not to send denial letters since members were unaware of the incentive.
5. After the mail drop on 05/28/20 to 74,651 members there was an influx of mailed-in incentive forms that were not filled out in its entirety or was filled out incorrectly. Members did not carefully read the instructions requiring an attested visit to be filled in by their provider. The denials and return process created an administrative burden.
6. The sheer volume of the denominator makes the program unstainable due to the drain on budgetary resources, processing burdens and ultimately a minor impact on the rates despite a relatively large volume of submissions. The year was not over and the expenditure was $169,275.

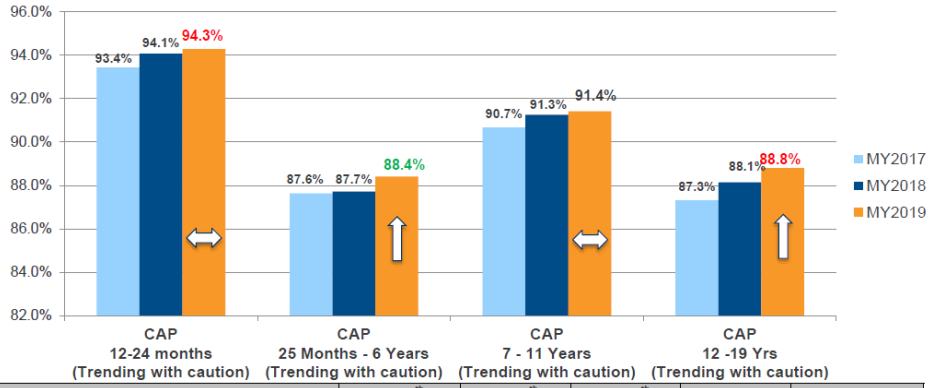
E. Opportunities for Improvement

1. Discontinue AWC incentive when the incentive period ends on 12/31/2020 due to the depletion of budget for member incentives, and an anticipated low impact on such a large numerator.
2. Stop doing targeted AWC mailings as the response rate was low (0.30%).

Children's Access to Primary Care Practitioners (CAP)

Performance Against Goal:

The rate for CAP and its submeasures is presented below. The 12–24 months and 12–19 years submeasures did not meet MPL. The 25 months–6 years and 7–11 years met the 50th percentile MPL. Only, 25 months–6 years CAP submeasure met goal of 87.87%. The 12–19 years submeasure is a P4V measure.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Children's Access to Primary Care Practitioners (CAP)					
12 - 24 Months	95.62%	97.04%	97.82%	95.62%	
25 Months - 6 Years	87.87%	90.32%	92.59%	87.87%	
7 - 11 Years	91.08%	93.41%	95.85%	92.33%	
12 -19 Years	90.21%	92.29%	94.64%	90.21%	P4V

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

2019 Children's Access to Primary Care Practitioners Initiatives: Medi-Cal

- Health Guide newsletter mailings discussed the importance of well-care visits, vaccinations, developmental milestones, healthy eating, care safety and other health education pertaining to the age group.
    - Health Guide 0–2 newsletter dropped 06/21/2019, targeted outreach to 10,991 members ages 0–2 years, who were due for CIS and/or W15.
    - Health Guide 3–6 newsletter dropped 07/10/2019, targeted outreached to 45,002 members ages 3–6 years, who were due for W34.
    - Health Guide 7–12 newsletter dropped 11/29/2019, targeted outreach to 14,975 members ages 12 years, who were due for AWC.
- CalOptima Day collaboration with HNs and provider offices hosted a health and wellness event focused on children and adolescents due for W15, W34, AWC, CIS and/or IMA.
    - Q2 2019 events: 11 sites participated, with a total of 18 events, which outreached to 870 members.
    - Q4 2019: three sites participated, which outreached to 129 members.
- Member incentive programs
    - Well-Child 4–6 Visits member incentive launched 09/01/2019. Incentive program awarded members $50 gift card to members ages 0–15 months old who completed at least six well-child visits before child's 15th month birthday. There were 276 total submissions.
        - Targeted Well-Child Visits 4–6 member incentive program mailing dropped 09/03/2019 and outreached to 1627 members who were identified as having an opportunity to complete six well-child visits before 15 months old.
- Provider incentive programs
    - Incentives were sent to 49 providers for participating in the Well-Child 4–6 Visits provider incentive program. Total payout for Q4 2019 is $9,550. Note: a few Q1 2020 was accidentally processed along with this batch.
- The 2019 Medi-Cal newsletter highlighted the *Don't Forget to Vaccinate, Get Shots at No Cost* article discussing the importance of well-care visits, immunization requirements for kindergarten and information on measles. The newsletter was mailed to 449,967 Medi-Cal members.
- Targeted W15 call campaign was conducted between 09/13/2019–10/04/2019 targeting members who have an opportunity to complete six well-child visits before turning 15 months old and to

promote the Well-Child 4–5 visits member incentive. There was 724 members who were outreached telephonically, with 574 successfully (live person or left voicemail).
- The W15 root cause analysis via survey to new mothers asking them where they took their children for their first two well-child visits and when. There were 94 call attempts made and with 31 successful live-person calls. Of that, 27 parents were able to recall a well-child visit date of service and 22 newborns had at least one well-child visit in the first three months of life.
- A fax blast was sent to 273 PCPs of members with outstanding W15 visits that explained the W15 HEDIS measure and the Well-Child 4–6 Visits incentive.

2020 Children's Access to PCP Initiatives: Medi-Cal

- Health Guide newsletter mailings discussed the importance of well-care visits, vaccinations, developmental milestones, healthy eating, care safety and other health education pertaining to the age group.
  - Health Guide 0–2 newsletter dropped 07/24/2020, with targeted outreach to 8,960 Medi-Cal members ages 0–12 months.
  - Health Guide 13–17 newsletter and AWC incentive mail dropped 05/28/2020, with targeted outreach to 74,651 members ages 13–17 years, who were due for AWC.
  - Health Guide 18–21 newsletter mail dropped 05/22/2020, with targeted outreach to 35,799 Medi-Cal members ages 18–21 years.
- IVR Call Campaigns
  - The W15 IVR call campaign slated for Q1 2020 was delayed due to COVID-19. Since Early and Periodic Screening, Diagnostic and Treatment (EPSDT) IVR campaign had similar messaging, W15 IVR was put on hold.
  - AWC IVR campaign slated for Q2 2020 was put on hold due to COVID-19. Messaging does not currently align with best practices during the pandemic.
  - EPSDT IVR campaign slated for Q3 2020 was put on hold. Messaging promoted preventative care to Medi-Cal members ages 0–2 and 3–6 years.
- Communications
  - Included *Well-Child Visits During COVID-19 Pandemic* article in the May Provider Update discussing the importance of continuing well-child visits during the pandemic in accordance with AAP guidelines. Care for newborns and well visit and immunizations of infants and young children (through 24 months of age) are prioritized.
  - Included *2020 CalOptima Member and Provider Incentive Programs* article in the July Provider Update. Article discusses CalOptima's PHM incentive opportunities, clarifies incentive eligibility requirements, and reiterates the W15 member and provider incentive criteria.
  - Promoted the Health Guide 13–17 and Health Guide 18–21 newsletter via Community Connections in July 2020.
  - Launched *Don't Wait—Vaccinate*, immunization campaign and article promoting vaccinations during the pandemic on the CalOptima website, went live 08/21/2020.
  - Included *Well-Care Visits and Vaccinations During a Pandemic* in the Orange County Immunization Coalition Summer newsletter

- **Incentives**
  - Well-Child Visits 1–3 (W15) member incentive program for Medi-Cal members who completed at least 3 well-child visits in the first 6 months of life received a $50 gift card.
  - Well-Child Visits 4–6 (W15) member incentive program for Medi-Cal members who completed at least 6 well-child visits by their 15-month birthday received a $50 gift card.
  - Well-Child Visits 1–3 and Well-Child Visits 4–6 provider incentive of $50 for each completed incentive form for eligible members.

    - Annual Well-Care Visits 12–17 (AWC) member incentive program launched January 2020 for Medi-Cal members who need to complete their annual well-care visit.

- CHOC Health Alliance held CalOptima Day Events 03/04/2020–03/05/2020 which focused on well-care visits for members due for either W15, W34 or AWC. There were 125 CalOptima Medi-Cal members that received service.
- September 2019 launched Post Bright Steps Well Baby Follow-Up Call project. After a mother graduates from BSP and completed the Postpartum Assessment, the Bright Steps team created an activity to follow-up with the baby in either two weeks or when baby was three months old depending on their risk level.

Barriers
- Due to the COVID-19 pandemic, there was a drop in PCP visits starting March 2020. Recommendation for provider offices visits changed. CalOptima's June 2020 Prospective rate reports show a decline when compared to the same time last year. The community was reluctant to go in for their preventive care screenings due to COVID-19.
- Preventative care visits were prioritized for pediatric members 0–2 years old during the pandemic and extended to populations who were due for their vaccinations.
- CAP measure was directly associated with other pediatric measures such as, but not limited to: W15, W34, AWC and WCC. Since other measures have been impacted due to COVID-19, CAP measure shows a decline as well.

Opportunities for Improvement
- The CAP measure were retired by NCQA.
- Focus on other pediatric measures which align with CAP measure parameters.

Overall Evaluation of Quality Initiatives

In 2019 and 2020, quality initiatives were numerous and required many resources. While there were many interventions and activities, not all efforts yielded the maximal return on investment. Some of the more resource-intensive initiatives did have merit. Events such as the CalOptima Days — while staff, time and financially resource-intensive — produced real qualitative benefits including more hands-on engagement with HN quality administrators. The W15 member and provider incentive required overall much more interaction with provider offices, to provide clarification and explanation of the incentive specifications as well as HEDIS requirements. This created opportunity to clarify the well-care visit schedule expectations that would meet the W15 acceptable timeline to satisfy the measure requirements. As a result, some providers changed their appointment schedules in response to that clarification. In addition — especially during the 2020 pandemic period — preliminarily, the engagement in member and provider incentives showed a surge whether it was due to an additional financial need created because of the economic ramifications or whether members and providers became more mindful of health opportunities and also had more time to address them. Furthermore, many provider offices which submitted incentives on behalf of their patients explained that they had more time due to the lull in patient flow, which allowed them to review patient charts and submit incentives on their behalf. We can only assume that member experience has likely significantly improved due to the increased number of rewards mailed to members during the pandemic.

In spite of some of these benefits to some of these more resource involved initiatives, it is clear that the impact on the HEDIS numerator (which closes a gap in member care) for many of these

measures were not impacted in measure to the efforts expended. CalOptima Days required heavy staff, financial and time investment, however, the number of hits that would affect HEDIS were comparably low to the resources invested. Events such as the Mobile Mammography brought high value with member experience to CCN members, however, each event was resource intensive, requiring staff across multiple departments to do outreach calls and make arrangements with the vendor as well as finding the community location that would be the best fit. It is not to say, that the impact on the numerator is the ultimate goal for each initiative, however, there must be a consideration of all factors involved to determine which initiatives to put resources towards in the next work plan year with limited resources.

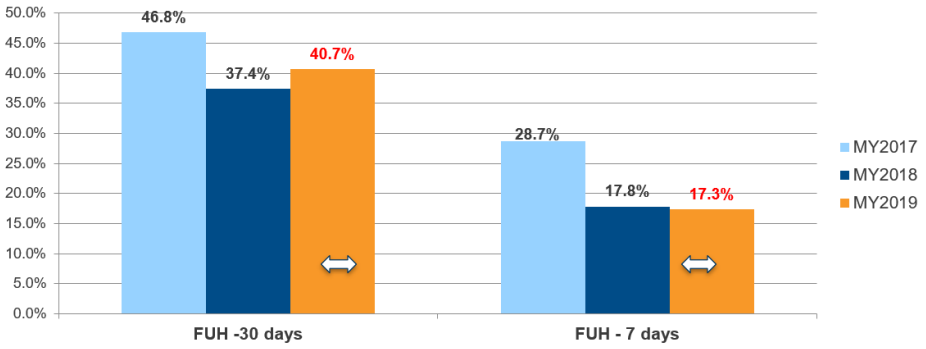
Probably the heaviest lift in 2019 and 2020 were the renovation and addition of new member and provider incentives. In making changes to existing incentives — and adding the W15, the AWC Medi-Cal incentives, and the Colorectal and Breast Cancer Medicare health rewards — the internal effort affected every QI work team from defining the parameters, revising content, program design, graphic design, promotion and marketing to the creation of an ever-evolving internal database to track all incentives efficiently. The largest unexpected burden was the incentive processing which was not anticipated to be as burdensome as it was in execution. The especially large and constant influx of AWC member incentives required the involvement of 12–15 other departmental staff in various capacities to tackle the processing requiring overtime hours. The department is preparing for an incentive RFP to select a member health rewards vendor to open up solutions for a more comprehensive gaps in care overall quality initiative to be developed with a multi-prong communication and member engagement plan.

Overall, in view of the many increases and improvements seen across priority measures, the strongest recommendation is for the focus and efforts be primarily channeled into the improvement of data exchange between CalOptima and all contracted HNs, providers and labs. The exchange of data sparked opportunities for discussion of expectations and sharing of how best to utilize data available at both the provider and health plan level. Through significant efforts to bridge data gaps for W15, connecting the mother’s CIN with her child’s well-care visits and obtaining much needed supplemental data was vital to the improvement of rates.

In the next HEDIS year, many of the measures previously hybrid in nature, will be changing into administrative only data opportunities. The need to address significant gaps and missing data especially in terms of lab data and early well care visits will be vital in helping CalOptima remain performing at or above a MPL for DHCS MCAS measures and for established goals. Access to electronic medical record systems for contracted HNs whether through Office Ally or other contracted means will not only open up CalOptima’s access to much needed encounter data but should also help remedy the lab data gap which is not currently obtained through current limited lab contract data exchanges. Addressing the data gaps will also provide us with accurate and timely information to plan and develop targeted initiatives to the appropriate populations.

Behavioral Health Quality Initiatives

Follow-Up After Hospitalization for Mental Illness (FUH)



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	46.16%	59.74%	71.43%	56.00%	CMS, Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	24.79%	34.33%	45.62%	18.20%	CMS

*Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure
↑ ↓ statistically higher or lower ↔ statistically no difference

Completed Activities in 2020

- In Q1 2020, the Behavioral Health Integration (BHI) management team in partnership with Network Relations visited the top three hospitals with inpatient psychiatric admissions to discuss concurrent review and transition of care management process. The team educated hospital staff about CalOptima's resources and expectations.
- BHI created and implemented a personal care coordinator position to conduct member outreach after member is discharged from hospital to coordinate follow-up appointments. The personal care coordinator also assisted members in securing a follow-up appointment if necessary.
- A report was developed based on data in Guiding Care to track the personal care coordinator outreach activities and post discharge follow up visit in real time. When members did not have a follow up appointment within seven days of discharge, the personal care coordinator outreached to members to identify barriers and secure a visit within 30 days.

A Transition of Care Management (TCM) team was created to building and maintain relationships with hospitals. The team meets with the Behavioral Health (BH) Medical Director weekly to discuss concurrent reviews and internal coordination interventions.

- Credentialed HCA providers who were qualified to provide Medicare covered BH services.

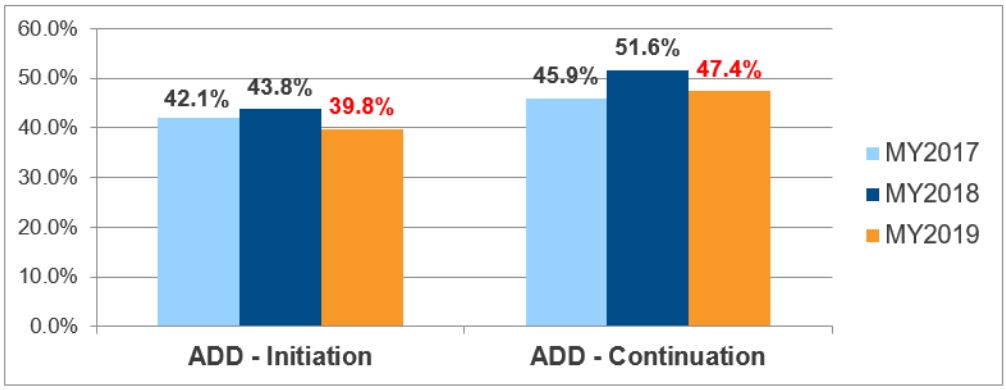
Barriers

- The discharge planning procedure is not standardized among the hospitals that serve our members. In addition, some hospitals lack understanding of the HEDIS requirements for FUH.
- The personal care coordinator was not always able to contact members after they have been discharged from the hospital — particularly if they are homeless or did not provide the hospital with their most current contact information.
- CalOptima is not able to credential some HCA providers due to the board certification requirement. As a result, the County has not been able to bill CalOptima for some of the outpatient psychiatric care provided at county clinics.

Opportunities for Improvement

- The BHI department implemented several virtual care strategies, including eVisits and telehealth, that helped expand access to behavioral health services. Those strategies offer members more options for follow up visit to meet their needs.
- The TCM team will continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment.
- The BHI management team will conduct additional hospital visits to educate discharge planning staff about FUH requirements and address any questions or concerns.

Follow-Up Care for Child ADHD (ADD)



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	43.41%	49.86%	56.57%	48.00%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	55.50%	62.69%	69.15%	55.50%	ACC, RS

*Red = less than 50th percentile, Green= met goal,
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2020

1. BHI created a report to track/trend providers who are non-compliant with this measure. Providers with high frequency of non-compliance were sent a letter to inform them about ADD requirements and the importance of follow-up visits with patients prescribed with ADD medications.
2. The provider education letter was updated to include more details about the requirements and the rationale for follow-up visits.

Existing Barriers

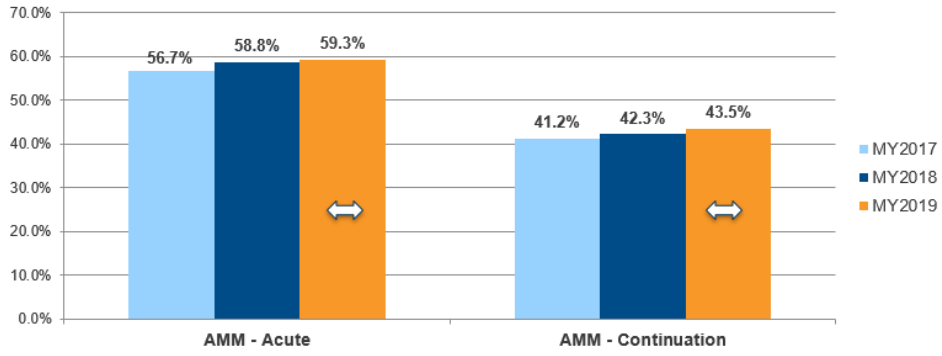
1. The provider letter was mailed to the address on record. We discovered that some of the letters went to an administrative office, which the provider may not be at that location. Also, a few of the letters were returned to CalOptima due to wrong address.
2. We are also aware that providers receive many materials from health plans and other businesses. It is possible that not all providers will read the letter or pay close attention to it; therefore, reducing the overall impact of the intervention.

Opportunities for Improvement

1. The BHI Quality team will continue to send letter to providers who are not meeting the ADD requirements.
2. Providers can schedule an appointment with members who need ADD follow up visit. However, members might have other reasons for not showing up for the appointment. The BH Quality team will explore opportunities to conduct member outreach to identify barriers and assist member with appointment scheduling if necessary.
3. Some of the ADD materials have not been updated for several years. Once updated, the team will distribute the new materials to providers and members as part of the outreach effort.

Antidepressant Medication Management (AMM)

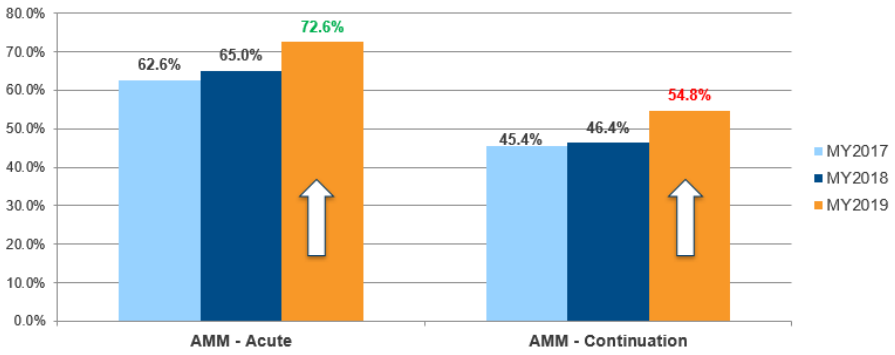
Medi-Cal AMM



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	52.33%	56.41%	65.95%	61.18%	MPL
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	36.51%	40.95%	48.68%	44.82%	ACC, RS, MPL

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

OCC AMM



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	71.60%	77.19%	83.33%	66.91%	CMS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	56.17%	61.31%	67.07%	50.39%	CMS

*Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure
↑ ↓ statistically higher or lower ↔ statistically no difference

Completed Activities in 2020

1. The BHI quality team reviewed and updated educational brochure for members on depression and treatment compliance.
2. The development of the Living with Depression video posted on CalOptima's website as part of the Health and Wellness Self-Care Guides for members.

Existing Barriers

1. It became apparent after updating the English version of the depression brochure, that a direct translation of the content to other languages may not meet the needs of various ethnic groups.
2. Members attending doctor appointments via telehealth; therefore, unable to pick up the brochure
3. BHI staff had multiple meetings with Provider Relations (PR) department to discuss the distribution of the brochure. Several challenges were identified including:
    - Temporary closure of providers' offices
    - PR staff not conducting in-person visits

Opportunities for Improvement

1. Offer digital version of the depression brochure to providers so they can share and discuss the material with members during telehealth visit.
2. Develop culturally appropriate version of the depression brochure for various ethnic groups.
3. Develop a HEDIS reporting tip sheet to educate providers about AMM requirements.
4. Educate members about the importance of depression medication adherence via member newsletters and social media.

Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. DSF requires providers to screen patients ages 12 years and older for clinical depression using standardized depression screening tools AND if positive, provide and document a follow up plan. Since DSF is still a relatively new measure, there is currently no benchmark to evaluate performance. CalOptima had been tracking the measure and conducted improvement activities.

Completed Activities in 2020

1. Depression screening, i.e. PHQ9, was completed as part of CalOptima's health needs assessment (HNA) for Whole-Child Model, complex case management, and care coordination.
2. Successfully loaded PHQ scores recorded in our Medical Management system to HEDIS software.
3. The BHI quality team updated the depression brochure which will be used as outreach material for members and providers.
4. The development of the Living with Depression video posted on CalOptima's website as part of the Health and Wellness Self-Care Guides for members.

Existing Barriers

1. It became apparent after updating the English version of the depression brochure, that a direct translation of the content to other languages may not meet the needs of various ethnic groups.

2. The number of provider educational events dropped significantly due to COVID-19. As a result, there was no opportunity to promote depression screening and treatment in the community.
3. Fewer members are scheduling routine care visits (i.e. well child visit, annual physical exam) resulting in fewer opportunities for providers to conduct depression screenings.

Opportunities for Improvement

1. Develop member information encouraging them to schedule routine/annual visits to increase opportunities for depression screenings.
2. Develop culturally appropriate version of the depression brochure for various ethnic groups.
3. Develop a HEDIS reporting tip sheet to educate providers on the importance of depression screening, available screening tools, and treatment options.
4. Explore ways on how to incorporate tools into CalOptima's internal system to gather data from providers.
5. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

Transition of OC and OCC Behavioral Health

In May 2019, CalOptima's Board of Directors approved transitioning OC and OCC BH services from Magellan to CalOptima. Multiple departments were involved in the implementation including Contracting, Provider Relations, Claims, Customer Services, BHI, Information Services, UM, RAC, and Process Excellence. On January 1, 2020, CalOptima started managing OC and OCC BH services including inpatient psychiatric care, outpatient behavioral health services, and opioid treatment program services. CalOptima was able to directly contract with most of the providers who were seeing our members through Magellan. Providers also had the option to sign a Letter of Agreement (LOA) to continue to see our OC and OCC members if they chose not to contract with CalOptima. The CalOptima BH Line leveraged existing protocols to manage OC/OCC BH calls. Overall, the transition went smoothly with minimal disruption to members care.

Safety of Clinical Care

Opioid Utilization

Opioid Utilization Data 2019–2020 Results

CalOptima Medi-Cal Opioid Analgesic Utilization	2019-Q3	2019-Q4	2020-Q1	2020-Q2	2020-Q3	% Change 3Q19 to 3Q20
Opioid Analgesic Rxs	38,426	35,927	33,616	31,268	34,530	-10.1%
% Members Utilizing Opioid Analgesic Rxs	1.09%	1.01%	0.99%	0.88%	0.97%	-11.3%
Opioid Analgesic Rxs PMPQ	0.021	0.020	0.019	0.017	0.018	-12.3%
Members Receiving > 80mg Avg MME	604	537	487	456	457	-24.3%

% Utilizing Members Receiving > 80mg Avg MME	3.01%	2.88%	2.78%	2.88%	2.50%	-16.7%
Average Quantity/Rx for Short-Acting Opioid Analgesics	51.7	52.0	52.6	54.6	51.0	-1.3%

CalOptima Opioid Utilization Goals	2019-Q3	2019-Q4	2020-Q1	2020-Q2	2020-Q3
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	13.1	12.3	12.0	11.4	10.9
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	2,639	2,469	2,362	2,179	2,391

CMS Medicare Star Display Measures

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D): Multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer and not in hospice care.

- Measure 1: Use of Opioids at High Dosage (OHD): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer.
- Measure 2: Use of Opioids from Multiple Providers (OMP): Members receiving prescriptions for opioids from four or more prescribers AND four or more pharmacies.
- Measure 3: Use of Opioids at High Dosage and from Multiple Providers (OHDMP): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies.

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage in Persons without Cancer	OneCare	2%	7%	Equal or Better
Use of Opioids at High Dosage in Persons without Cancer	OCC	5%	7%	Equal or Better

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids from Multiple Providers	OneCare	0%	0%	Equal or Better

Use of Opioids from Multiple Providers	OCC	1%	0%	Equal or Better

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage and from Multiple Providers	OneCare	0%	0%	Equal or Better
Use of Opioids at High Dosage and from Multiple Providers	OCC	0%	0%	Equal or Better

** Medicare-Advantage Prescription Drug*

Completed Pharmacy Management Interventions in 2020

Prescriber

1. Quarterly prescriber report card: Intervention provided to providers whose average Milligram Morphine Equivalent (MME) dose per prescription fell above their practice specialty average.
2. Prescriber newsletters:
    - FDA Warning of Respiratory Depression for Gabapentinoids with Concomitant Opioids
    - Opioid Quality Measure Update
3. Monthly Medicare Opioid Overutilization Intervention: Member opioid and benzodiazepine medication list faxed to most recent prescriber of members who meet CMS Opioid Monitoring System (OMS) Criteria.

Pharmacy

1. Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection (overridable by the pharmacist) and exceeding 400mg will trigger a hard rejection (authorization required).
2. Point of service soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

Member

1. Retrospective identification of members meeting criteria for opioid overutilization for Medical Director Review and referral to Compliance, QI or Case Management.
2. Pharmacy Home Program Policy: Members filling prescriptions at four or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
3. Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the members filling controlled substance prescriptions from four or more prescribers in a two month period are restricted to designated prescribers.

Formulary

Medi-Cal

1. Point-of-sale (POS) pharmacy edits triggering a soft rejection for opioid pharmacy claims attempted to be filled within 30 calendar days of a fill for buprenorphine-containing products.
2. Require prior authorization for new starts for methadone doses above 30mg/day.
3. Require prior authorization for new starts for all long-acting opioids.
4. Stricter quantity limits for short-acting opioid analgesics.
5. Concurrent use of opioids and opioid potentiators (such as benzodiazepines or gabapentinoids) formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate National Council for Prescription Drug Programs (NCPDP) codes upon review of drug therapy.

Medicare

1. Hard safety edit to limit initial opioid prescription fills to no more than a seven-day supply.
2. Pharmacist-driven care-coordination formulary safety edit for duplicative long-acting opioid therapy (excluding buprenorphine) with a prescriber count of at least two prescribers that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

3. Pharmacist-driven opioid care coordination formulary safety edit would trigger when a member's cumulative MME per day across all opioid prescriptions reaches or exceeds 90 MME.
4. Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Existing Barriers

1. Lack of timely data from DHCS for Medication Assisted Therapy (MAT) medication carve out claims for Medi-Cal members.
2. No access to data for medications dispensed by Opioid Treatment Programs (OTP).

New Opioid Interventions Completed in 2020

1. Effective October 1, 2019, CalOptima's Medi-Cal DUR program complies with section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS: opioid pharmacy claims for members shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/day without prior authorization.
2. Promote Medication Assisted Therapy (MAT): The use of FDA-approved medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
3. Contract with OTP for Medicare members effective January 1, 2020.

In 2021, the Medi-Cal outpatient pharmacy benefit will be carved out to the state. There are no planned interventions at this time.

Post-Acute Infection Prevention Quality Incentive (PIPQI)

PIPQI is a CalOptima quality initiative program shown to reduce antibiotic-resistant bacteria in hospitals and nursing homes. Participating nursing facilities utilize chlorhexidine (CHG) bath soap for all baths and showers and Iodophor nasal swabs bi-weekly. Currently, 26 nursing facilities participate in PIPQI. CalOptima nurses monitor compliance with CHG and nasal swab usage, Hospital Acquired Infection (HAI) scores, and hospital admissions/readmissions due to infections.

COVID-19 presents the following barriers:

- Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.
- High turnover rates in facilities creates a need for constant PIPQI training.
- Due to COVID-19, CalOptima nurses are not allowed to conduct on-site visits for monitoring or training of facility staff.

CalOptima nurses began monitoring compliance with PIPQI via telephone in March 2020, conducting phone consultations and training. One training video per month is reviewed with all participating nursing facilities. Quality performance measures will be monitored in 2021. PIPQI will be made available to additional facilities per request of facility in 2021. Consultation and training will continue via telephone and webinar until CalOptima nurses can resume on-site visits to nursing facilities.

Additionally, CalOptima partnered with HCA and University of California, Irvine (UCI) to implement the OC Nursing Home COVID-19 Infection Prevention Training Program. Aimed at keeping patients, staff and families as safe as possible during the pandemic by preventing virus spread. Program includes intense in-person training of 12 CalOptima contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima OC contracted nursing facilities.

Goals:

- Outfit OC nursing homes to prevent COVID-19 as soon as possible, but especially in time for fall surge.
- Provide expertise on infection prevention for COVID-19/SARS-CoV-2.
- Provide guidance, protocols for preventing spread of COVID-19.
- Support training on how to stock and use protective gear.
- Develop high compliance processes for protection of staff and residents.

Program was implemented in June 2020 and will run through May 2021. On average, approximately 60 people attend the webinars from approximately 20 nursing facilities. Training materials can be found at uci.org/stopcovid

2019–2020 Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects for 2019–2020 by each improvement project type.

QIPs: OCC Population and NCQA Patient Safety Standard – Medi-Cal

1. Improving Statins Use for Patients with Diabetes (SPD) 2019–2020

The improving statin use for patients with diabetes mailing intervention targets all three LOBs; Medi-Cal, OC and OCC. The Medi-Cal results will be reported to NCQA to satisfy the Patient Safety standard. OCC results will be reported to CMS as part of a QIP. There is no QIP requirement for the OneCare population however CalOptima chose to still include this small population as part of the SPD intervention.

Goal
To increase statin use among members with diabetes by 5%.

Target Population
All CalOptima members who are diagnosed with diabetes.

Interventions
A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima members diagnosed with diabetes. An SPD member mailing was sent in tandem with an existing provider focused program to promote statin use among members diagnosed with diabetes and to encourage members to have a discussion with their health care providers about whether a statin is right for them.

Activities
Quarterly mailings and the IVR messaging campaign promoting the discussion with their providers have been put into place to encourage members to consider the potential benefits of preventing cardiovascular complications.

Mailing Summary
Program implemented in Quarter 4, 2019. Data collection is in ongoing for all three LOBs.

SPD Member Quarterly Mailings						
	Q1 2020			Q2 2020		
LOB	Member Count	Members Eligible Sent	Members Received Intervention	Member Count	Members Eligible Sent	Members Received Intervention
OneCare	87	40	32	61	8	5
OCC	761	276	146	630	125	46
Medi-Cal	6150	2334	1006	5320	1007	278
Total	**6998**	**2650**	**1184**	**6011**	**1140**	**329**

2019 Interactive Voice Recording (IVR) A1c and Statin Use Campaign				
Disposition	Medi-Cal	OneCare	OCC	Grand Total
Successful IVR call	17001	121	1033	18155
Unsuccessful IVR call	35101	148	2174	37423

Overall, we had a 32.67% successful IVR call rate across all three LOBs. Members were contacted telephonically via robocall with a message emphasizing the importance of scheduling an A1C test and promoting the discussion of statin use with their health care providers to reduce cardiovascular complications.

Performance Improvement Projects (PIPs)

1. **OCC PIP: Members with Individualized Care Plan Completed/Members with Documented Discussions of Care Goals 2018–2019 Completed April 2020**

Goals

1. CA 1.5 – Members with an Individualized Care Plan Completed
   Year 1 Goal: High Risk: 48.89%; Low Risk: 38.81%
   Year 2 Goal: High Risk: 52.09%; Low Risk: 41.06%

2. CA 1.6 – Members with Documented Discussions of Care Goals
   Year 1 Goal: 77.91%
   Year 2 Goal: 81.57%

Interventions

1. Change language with Health Risk Assessment (implemented 1/3/18)
2. Initiate Initial Care Plan (ICP) discussion goals at the first contact with member

Summary of Results

Study Indicator 1	
Study Indicator 1 Title	CA 1.5 High Risk with an ICP completed. (56.45%)
Measurement Year Goal	52.09%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	High Risk (B/A) Quarter 1: (2019) 53.23% (PDSA cycle 4) Quarter 2: (2019) 54.57% (PDSA cycle 5) Quarter 3: (2019) 55.68% Quarter 4: (2019) 56.45%
Study Indicator 2	
Study Indicator 2 Title	CA 1.5 Low Risk with an ICP completed. (68.48%) – 90 days continuous enrollment
Measurement Year Goal	73.48%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	Low Risk (D/C) Quarter 1: (2019) 41.87% Quarter 2: (2019) 43.03% Quarter 3: (2019) 43.70% Quarter 4: (2019) 44.45%
Study Indicator 3	
Study Indicator 3 Title	CA 1.6 OCC Members with Documented Discussion of Care Goals (74.81%)
Measurement Year Goal	81.57%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 3) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 4) Quarter 3: 07/01/2019 to 09/30/2019 (PDSA cycle 5) Quarter 4: 10/01/2019 to 12/31/2019

Results	Quarter 1: (2019) 93.01% (PDSA cycle 3) Quarter 2: (2019) 90.21% (PDSA cycle 4) Quarter 3: (2019) 91.02% (PDSA cycle 5) Quarter 4: (2019) 92.19% Cumulative Rate (up to end of each cycle/quarter): 1/1/18–3/31/19: 93.01% 1/1/18–6/30/19: 91.55%

For study indicators 1 and 2, changes made to our data collection process in response to regulatory guidance to only count care plans that had proof of member involvement resulted in a change to our data collection process. Our prior process did not have a positive review question that addressed member involvement. When we made the change, it allowed us to collect data specifically aimed at that question for each quarter going forward. However, since this is a cumulative measure, and the target criteria have been modified, when we applied the same logic, we lost the ability to count many care plans that were created prior to the question being implemented.

The CA 1.5 High-Risk rate improved from 52.09% in 2018 to 56.45% in 2019 for an increase of 4.36 percentage points. The 2019 rate of 56.45% was 7.56 percentage points higher than the goal rate of 48.89%. This showed sustained and increasing improvement. Because of the large numbers in the numerator and denominator Fisher's exact test was not performed, but Chi-Square without Yates' correction was used instead (Chi-Squared equals 20.804 with 1 degrees of freedom). The test's two tailed p-value was less than 0.0001 and yielded an extremely statistically significant outcome.

The CA 1.5 Low-Risk rate improved from 41.06% in 2018 to 44.45% in 2019 for an increase of 3.39 percentage points. The 2019 rate of 44.45% was 5.64 percentage points higher than the goal rate of 38.81%. This showed sustained and increasing improvement. Because of the large numbers in the numerator and denominator, the Fisher's exact test was not performed but Chi-Squared without Yates' correction was used instead (Chi-Squared equals 1516.833 with 1 degrees of freedom). The test's two tailed p-value was less than 0.0001 and yielded an extremely statically significant outcome.

For study indicator 3, results continue to show strong improvement, with Q3 results indicating that 91.02% of members had discussions of care goals. In Q4, we achieved the rate of 92.19%, which exceeds our goal of 81.57%.This intervention is proving to be effective and will be continued.

CalOptima has satisfied all requirements for the OCC ICP PIP. We have demonstrated statistically significant improvement for two consecutive years for this PIP. This PIP project was completed and closed out in April 2020.

2. Medi-Cal PIP: Improving Well-Care Visits for Children in Their First 15 Months of Life (W15) for CalOptima Medi-Cal Members with Provider Office A

Goal
By June 30, 2021, increase the percentage of well-child visits among Medi-Cal members turning 15 months old for Provider Office A, from 41.51% to 51.61%.

Proposed Interventions
Provider and member incentive to increase well-child visits in the first 15 months of life.

1. Member incentives:
    - $50 for completed well-child visits 1-3
    - $50 for completing well- child visits 4-6
2. Providers are to receive the same amount verified through claims and encounters.

DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project. Awaiting guidance from DHCS to establish new PIP requirements at the end of 2020.

3. **Medi-Cal PIP: Improving Access to Acute/Preventive Care Services to Medi-Cal Members Experiencing Homelessness in Orange County.**

    Goal
    By June 30, 2021, increase the rate of acute and or preventive care services among Medi-Cal members 18 years and older identified as experiencing homelessness in Orange County from 41.8% to 43.2%.

    Proposed Interventions
    Implementing HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.

    DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project. Awaiting guidance from DHCS to establish new PIP requirements at the end of 2020.

CCIPs: OC and OCC and NCQA Emerging Risk Standard – Medi-Cal

Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8%

The improvement project targeting the emerging risk populations aimed at improving A1C Control <8% for Members Recently Experiencing Poor Control >8%. This intervention targets Medi-Cal, OC and OCC. The Medi-Cal results will be reported to NCQA to satisfy the Emerging Risk standard. The OC and OCC results will be reported to CMS as part of a CCIP.

1. **OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021**

    Goal
    Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OC members identified and who participate back to an A1C <8% within one year.

    Target Population
    OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.
    - These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

- Exclusion criteria:
  - Ineligible CalOptima members
  - Members identified for long-term care (LTC) or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets OC members with diabetes with A1C results trending upward from <8% to >8%. OC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results: The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (OC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached	Emerging Risk Members Incomplete Assessment	No Longer Eligible
2020	Q1	OC	0	0				
2020	Q2	OC	8	0	0	0	0	0

In Q1 2020, there were no OC members that were assigned to a health coach. (Only one member at the time and was recently outreached by a health coach on 12/31/2019.) For Q2 2020, there was eight in the starting denominator, but none were assigned due to accidentally assigning the Medi-Cal and OCC members first. Will prioritize OCC members first for Q3 2020.

2. OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2020

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an A1C <8% within one year.

Target Population
OCC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members were enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
- Exclusion Criteria:
  - Ineligible CalOptima members
  - Members identified for LTC or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets OCC members with diabetes with A1C results trending upward from <8% to >8%. OCC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results
The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached	Emerging Risk Members Incomplete Assessments	No Longer Eligible
2020	Q1	OCC	4	4	2	0	0	0
2020	Q2	OCC	85	8	6	1	1	0

In Q1 2020, 4 members were assigned to a health coach and 2 were successfully outreached telephonically. In Q2 2020, 8 members were assigned to a health coach and 6 were successfully outreached telephonically.

3. Medi-Cal CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to Medi-Cal members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of Medi-Cal members identified and who participate back to an A1C <8% within one year.

Target Population
Medi-Cal members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
- Exclusion Criteria:
  - Ineligible CalOptima members
  - Members identified for long-term Care (LTC) or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets Medi-Cal members with diabetes with A1C results trending upward from <8% to >8%. Medi-Cal members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned

approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results
The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (Medi-Cal)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached (#5 Yes)	Emerging Risk Members Unsuccessfully Outreached (#5 No)	Emerging Risk Members Incomplete Assessments	No Longer Eligible
2020	Q1	Medi-Cal	148	143	39	5	1	0
2020	Q2	Medi-Cal	731	35	22	1	12	0

In Q1 2020, 143 members were assigned to a health coach and 39 were successfully outreached telephonically. In Q2 2020, 35 members were assigned to a health coach and 22 were successfully outreached telephonically. We will continue to track and monitor this CCIP.

PDSA Initiatives

1. **PDSA – Improving Flu Vaccination Rates for the Medi-Cal Population**

In September 2020, DHCS required all MCPs to conduct a PDSA rapid cycle project on a single performance measure of the MCPs/PSPs choice that focuses on a preventive care, chronic disease management, or behavioral health MCAS measure impacted by COVID-19. MCPs/PSPs should provide evidence to support their choice of PDSA topic. DHCS will be flexible on the format and types of interventions for the PDSA cycles to accommodate for COVID-19 barriers. CalOptima has chosen to improve the Adult Immunization Status (AIS) measure, with a focus on influenza vaccinations. We are currently working the planning portion of this project. This PDSA will continue through the end of 2021.

2. **Initial COVID-19 QIP Submission**

In September 2020, DHCS required all MCP/PSP plans to submit a brief COVID-19 QIP to DHCS. The initial COVID-19 QIP (due to DHCS on October 2, 2020) submission included a description of the MCP's/PSP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care, for members amidst COVID-19. The second COVID-19 QIP submission (due to DHCS on March 1, 2020) should include a six-month progress update on the interventions and/or strategies. CalOptima has submitted the initial response back to DHCS on October 2, 2020.

SECTION 3: QUALITY OF SERVICE

Member Experience

CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

CalOptima monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and HN. The achievement score is the calculation of positive responses, typically identified as "Usually" or "Always" or rated top scores of "8, 9 or 10."

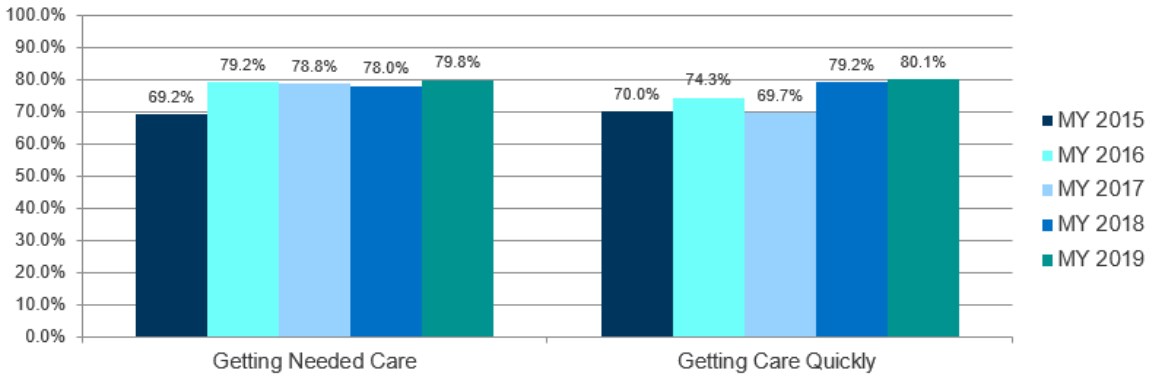
In early 2020, the world was struck by the COVID-19 pandemic. By mid-March, the state of California was under a state-wide lockdown (shelter-in-place) order. The CAHPS vendor's call center was closed and the vendor was unable to conduct the telephone follow-up calls. To address this issue, the survey protocol was modified from two mailings with a telephone follow-up to three mailings. While CalOptima's CAHPS survey still yielded approximately a 20% response rate, it's impossible to predict the effects of the pandemic on the survey results and survey results and any comparisons to trend data should be viewed with caution.

CAHPS Trend Analysis
CalOptima identified that the "Getting Needed Care and Getting Care Quickly" measures were consistently performing below goal. The following tables includes the plan level survey achievement scores for the adult and child surveys for two key measures (i.e. getting needed care and getting care quickly).

See next page for results.

Goal
To meet the 50th percentile when compared to National Medicaid Benchmarks.

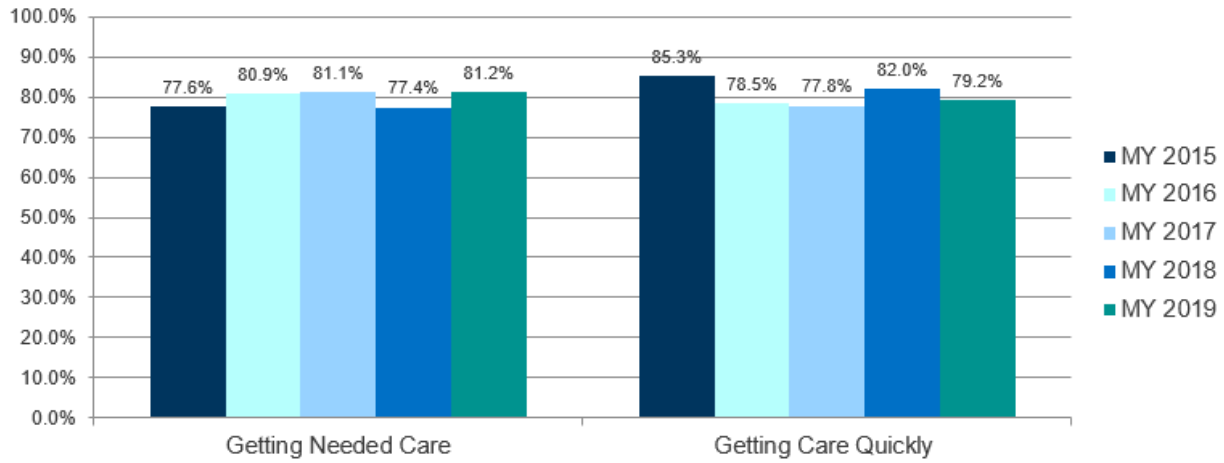
Medi-Cal Adult CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

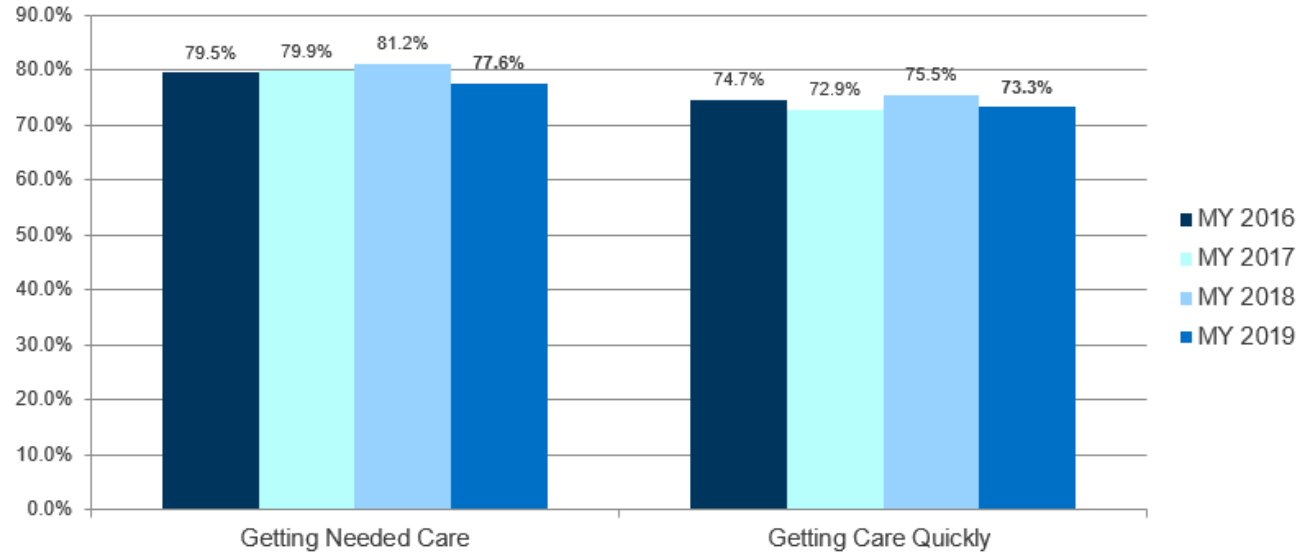
Medi-Cal Child CAHPS Survey Results



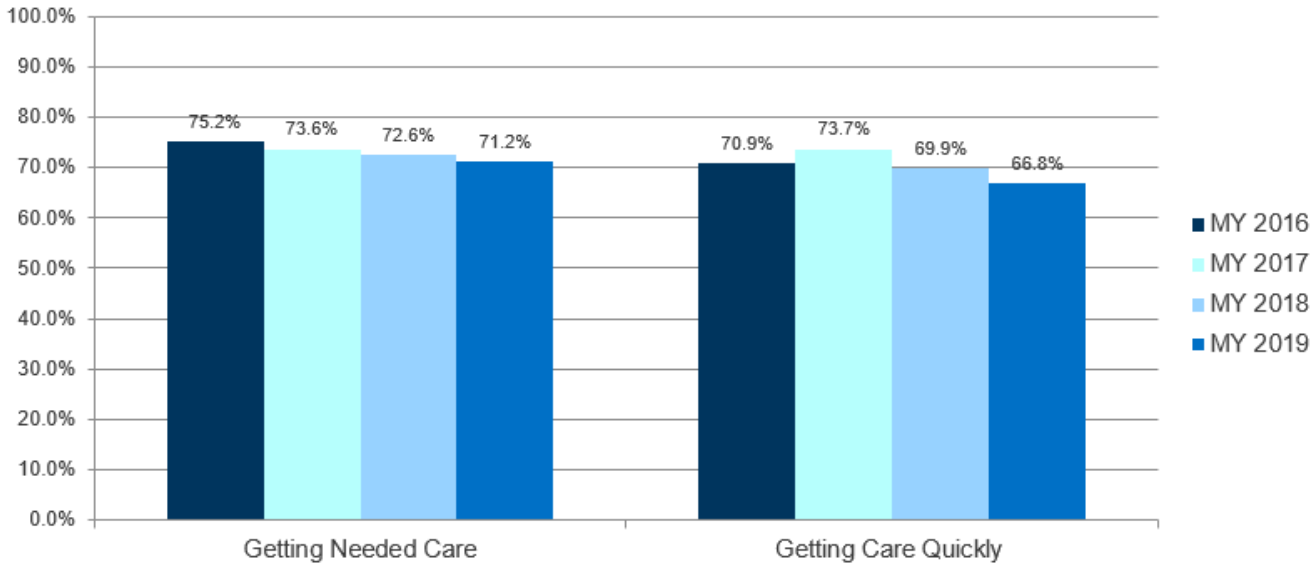
National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

Red = less than 25th percentile

OC CAHPS Survey Results



OCC CAHPS Survey Results



In 2020, CalOptima reviewed all the CAHPS rates in detail and compared them to the benchmarks and found the access CAHPS measures, getting needed care and getting care quickly, to be high priority for the organization.

Access to Care

Timely Access Study

CalOptima monitors appointment availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities, and lower spending and better overall member satisfaction with health care. CalOptima fields a mystery shopper timely access survey to collect appointment wait times and compares them to standards from DHCS and CMS. A compliance rate is calculated by appointment type for each provider type.

In early 2020, the world was struck by the COVID-19 pandemic. In light of the COVID-19 pandemic, CalOptima placed a temporary hold on conducting the Timely Access Survey to ease the burden and allow network providers to focus operations on COVID-19. This decision to hold place a hold on the survey is aligned with DHCS' discussion to hold their timely access survey of the plans. Since a 2020 survey has not yet been fielded, CalOptima utilized results from the 2019 Timely Access Survey to evaluate access.

As part of this survey, the survey vendor made 6,981 total contact attempts. Of that only, 71.1% of the contact led to a live contact and only 26.2% led to an appointment time that can be compared to the benchmark. The survey vendor was not able to reach a large portion of the provider survey population.

Goal:
To meet internal goal of 80% for each individual measure and practitioner types

Of the 26.2% of the survey population across all LOBs where the vendor was able to obtain an appointment for comparison against the standards, the data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. All of the standards by provider type, with the exception of physician exams for PCPs and follow-up appointments for non-physician behavioral health, did not meet the internal goal at 80%. Rates were particularly low for urgent appointments and appointments with specialists. Based on the review of timely access study results, appointment access is an area of concern. When evaluating timely access for each of CalOptima's delegated HNs, the HNs similarly did not meet the internal goal of 80% for most of the standards.

Network Adequacy — Time and Distance Analysis
CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the plan meets the time and distance standards established by CMS and DHCS. In 2020, DHCS issued an updated All-Plan Letter on Network Certification and provided more guidance on the meeting the standards and on how to run the reports. Plans are now required to meet both time and distance standards where each zip code must have members meeting 100% access and plans also need to account for anticipated membership using a methodology pulling from the 2010 census. For all LOBs, the plan has met the time and distance standards with the exception of ENT/Otolaryngology and Orthopedic Surgery and in one zip code in south OC for Medi-Cal. For these zip codes not meeting the standards, we have requested for approval for an alternative access standard with DHCS at the plan level and are awaiting DHCS' response. When evaluating network adequacy for each of CalOptima's delegated HNs, the HNs did not meet all the time and distance standards. HNs had challenges providing geographic coverage for specialists, particularly in south OC.

Comparison to Complaints/Appeals
When the CAHPS results were compared to the Access grievances, CalOptima found that access grievances make up about 10% of all grievances in 2020. Compared to the previous year, the percentage of access-related grievances have maintained the same as last year. The top three sub-categories of access grievances are appointment availability, specialty care, and referral related access grievances. Of the access-related grievances, appointment availability continues to be a pain point for members with approximately 26% of all access-related grievances.

In early 2020, as the world was struck by the COVID-19 pandemic, CalOptima received more Customer Service calls and grievances related to the pandemic. To better address these member concerns, a COVID-19 Member Experience workgroup was formed to monitor, track and trend COVID-19 related issues. The workgroup reviewed COVID-19 related calls from Customer Service, grievances, potential quality issues (PQIs) and provider calls and feedback. The top calls were related to COVID-19 testing, general inquiries about COVID-19 and inquiries about their provider and benefits, including pharmacy benefits. The top COVID-19 related grievances were related to delay in care and COVID-19 testing. For delay in care grievances, members were concerned about providers not seeing patients, appointment delay or cancelled appointments during the pandemic. COVID-19 testing related grievances were related to PCP/office not referring or denying member for testing or that the provider did not know where to refer the member for testing.

Member Experience Activities Completed in 2020
The Member Experience Subcommittee identified access, member engagement and virtual care strategies as the areas of focus for 2020.

Virtual Care Initiatives
A virtual strategies workgroup was formed to implement virtual initiatives to improve access to care. The workgroup also worked to identify resources and staffing as well and guide request for proposals and contracting efforts with vendors. On May 7, 2020, CalOptima obtained Board approval for overall Virtual Care Strategy and Roadmap.

1. Member Texting: CalOptima secured Board approval for three years of funding and contracted with mPulse on 7/28/20 to provide one-way and two-way interactive texting campaigns to members. Interface testing is in progress and the first two campaigns to be implemented will be COVID-19 and flu shots utilizing one-way messaging. Although we were technically ready to go in October, the campaign is on hold pending DHCS approval to use texting to communicate with members.
2. PACE Telehealth Solution: CalOptima secured Board approval for funding to implement a technology platform using VSee to support PACE staff (clinicians) virtual visits with participants at home or other remote locations that will replace the use of Facetime/Google Duo during COVID-19 and support long-term need to engage participants at home. Pilot was started in October and rolled out to all PACE clinical teams by early December.
3. eConsult: CalOptima intends to implement a system that allows PCPs and specialists to securely share health information and discuss patient care that may replace the requirement for authorizations. A RFP has been issued and vendor selection is targeted for January 2021.
4. Behavioral Health (BH) Virtual Visits: CalOptima contracted with Bright Heart to provide BH virtual visits to our members. Bright Heart providers have been credentialed and visits began in August 2020. BH providers have been utilizing referrals for BH services, and member liaisons have been utilizing referrals for medication management services.
5. 24/7 eVisits: CalOptima intends to provide 24/7 direct access to physician virtual visits via website link or nurse advice line referral. CalOptima obtained Board approval for funding to issue an RFP by December with a target to contract with a vendor by March 2021.

A Member Experience Subcommittee was held in the beginning of 2020, and the committee determined that, in addition to the virtual strategies listed above, the committee would aim to implement the following initiatives:

1. CalOptima contracted with SullivanLuallin Group, a customer service improvement health care consultant, to continue to conduct provider shadow coaching and to hold workshops on customer service for office staff, office managers/supervisors and physicians to improve overall patient experience. When the COVID-19 pandemic struck in March 2020, CalOptima suspended all SullivanLuallin in-person training efforts to provider offices to be in compliance with the state-wide mandate to shelter-in-place. Mid-year, CalOptima decided to sunset this program and focus efforts on improving access to our members during the COVID-19 pandemic. The contract with SullivanLuallin will expire near the end of the year.
2. Approximately 15 providers were sent a notification letter in 2020 to address PCP member panel overcapacity with panel closures and member reassignment. In light of COVID-19, CalOptima suspended the notification letters and panel closures mid-year to ease the burden and allow network providers to focus operations on COVID-19. In 2020, 10 PCPs had their panels re-opened because they had met capacity for three consecutive months.
3. The member portal release three and four were implemented in 2020.
    - New forms and user interfaces for new registrations, login, forgot password, logout pages, were successfully deployed in March 2020.
        - Multiple security enhancements were completed in March 2020.
        - A new COVID-19 related message was added to the member portal's landing page reminding members about self-service options such as ordering ID cards, changing PCPs, checking eligibility and submitting inquiries to Customer Service.
        - New member registrations continue increasing steadily at an average rate of 600 new members per week.
        - A Customer Service member portal support team responds to questions about the portal, helps members navigate site functions and provides basic troubleshooting of access issues.
    - Additional language support for Spanish and Vietnamese was deployed on 5/30/20.
    - New member representative forms and registration wizards were deployed on 5/30/20.
    - Interpreter services requests were successfully deployed on 5/30/2020.
4. CalOptima authorizations have been extended from 90 to 180 days to allow members more time to utilize the authorization and see their provider. This extension was particularly vital during COVID-19, when providers may be rescheduling patients' appointments due to the pandemic.
5. In 2020, through continued analysis of auto authorization rules in the Cerecons portal, an additional nine specialties were identified as having 98%+ approval rate and auto authorization rules developed and implemented for initial consults effective April 1, 2020.

During the COVID-19 pandemic, CalOptima implemented the following initiatives to immediately address the members' needs during the pandemic:

1. CalOptima updated the website to bring forth COVID-19 related information including information on how to get tested, pharmacy benefits, telehealth options and how to obtain additional resources.
2. Updated the CalOptima website search function for COVID-19 to make the content easier to find.
3. Customer Service staff conducts member outreach calls with an average of 1,200 members per month to wish happy birthday and reminder to get physicals. Effective March 2020 COVID-19 scripting replaced the birthday call script to education members on social distancing and availability of resources and services offered by CalOptima and 211. Calls also inform members

of medical benefits during the pandemic with additional care options such as telehealth visits and nurse advice line.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time and Distance Analysis and complaints data, the general theme that stands out is that appointment access and delay in care is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2021, CalOptima will continue focusing on the key initiatives that were implemented in 2020 and develop additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers

Based on the CAHPS and member complaints data, CalOptima has identified that getting needed care and getting care quickly are the most critical measures, and therefore are the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

Access and Availability

1. Lack of extended office hours for appointments can be a significant barrier.
2. PCPs have too many members in their panel.
3. There may be an adequate number of practitioners in CalOptima's panel but not all providers have open panels or are available to see CalOptima new patients.
   - CalOptima is a delegated model and members are only able to see a provider in their HN.
   - A particular PCP and specialist group will not see members that are not in their system.
4. Certain geographic areas in OC, particularly south OC, do not have an adequate number of specialists for a particular type of specialty (i.e. pediatric subspecialties, oncologists, rheumatologists, etc.).
5. Not enough specialists are willing to contract with CalOptima.
   - Low reimbursement rates in comparison to other types of health insurance.

Provider Data Quality

1. Members not always able to get through to their provider to make an appointment.
   - Member calls reached voicemail, a closed office, an answering service or no answer at all
2. Members are referred to and approvals are sent to specialists who cannot see the patient.
   - Specialists/subspecialties/area focus is not clear, or information is not captured.
3. Open/close panel is not up-to-date
   - No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
4. System issue: FACETS shows no longer accepting patients, but Guiding Care shows as participating without any restrictions.

Prior Authorization Process

1. Timelines of submission of PCP and specialist in an issue. Provider office staff wait to submit the authorization request.

2. Providers do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometimes required and may cause delay in obtaining services.
3. Since UCI provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process which may make members feel like it takes a long time.

Opportunities for Member Experience in 2021

The Member Experience Subcommittee identified access to care as the areas of focus for 2021. CalOptima has established the goal of improving member experience for getting needed care and getting care quickly from 25th to 50th percentile.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

1. Implement the virtual care initiatives in the Virtual Care Strategy and Roadmap, including implementation of an eConsult system to serve as a peer-to-peer communication messaging platform between PCPs and specialists which will improve patient access to specialty care and overall quality of care.
2. Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
3. Monitor Time and Distance Standards by HN. While DHCS is requiring all plans to certify their delegated networks on network adequacy access performance by July 1, 2022, CalOptima will begin monitoring adequacy of network at the HNs level and developing implementation plans, as needed, in 2020 to ensure that each HN meets time and distance standards.
4. Member portal release five development scheduled for deployment at end of Q3-2020. Enhancements targeted include redesign of Change of PCP forms, improved filtering of Medical Groups on Provider Search results, update position of Medical Group Affiliations fields, and general enhancements to the dashboard.
5. Need to accelerate member portal adoption in 2021 provider outreach and education via a notification letter to providers not meeting the timely access standards. An escalation process has been developed to track continue instances of non-compliance that may lead to further action (i.e. corrective action plan, freezing panels, sanctions, etc.).

RECOMMENDATIONS FOR 2021

Based on the 2020 QI Program Evaluation we recommend the following initiatives and projects to drive improvement in quality outcomes that impact our members.

1. Continue member health rewards incentive program, specifically for preventive screenings such as BCS, CCS, COL, as well as other areas to impact measures like CDC, and PPC linked to Bright Steps. Work collaboratively with HNs to widen the promotion of these incentives. Utilize a third-party vendor to help reduce the intense staff resources required to process member incentives.
2. Intensify member outreach, by utilizing multiple modes of communications to reach members, either through website, direct mailings, IVR calls, and mobile texting. Leverage more electronic means versus resource intensive direct member outreach, as part of a more robust user-friendly communication/touchpoint plan.
3. Continue to utilize P4V measure set to drive improvement on MCAS measures plus additional access measures. Institute new BH P4V program in 2021 to help drive improvement in BH measures.
4. Prioritize data bridge efforts to improve data exchanges, both at the HN and plan level. In 2021 since many of the measures that were previously hybrid, are now administrative, it is imperative that data gaps continue to be identified and addressed. In addition, access to electronic medical record systems for contracted HNs, will help reduce the need for medical record review (and reduce provider abrasion) and will gain access to clinical care data elements not submitted via claims or encounter data. Seek to expand collection of lab data and results such as blood lead registry data and remind HNs of the opportunity to send point of care lab data via our electronic data submission process.
5. Expand virtual care strategies to increase access to care for members, such as BH Virtual care visits, e-visits, e-consults, PACE telehealth, and member texting platform (mPulse).

Based on the thorough 2020 QI Program Evaluation — in addition to continuing to advance CalOptima mission and improving quality outcome of our members — we recommend the implementing the 2021 Quality Improvement Goals in alignment with CalOptima's Strategic Priorities.

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Action

Recommend approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program (QI Program) and Quality Improvement Work Plan (QI Work Plan) must be reviewed, evaluated and approved annually by the Board of Directors.

The QI Program defines the structure within which QI activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detailed objectives, scope, timeline, monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year and reported to the QI Committee quarterly.

CalOptima staff has updated the 2021 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks, and strategic organizational changes. This will ensure that all regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

Discussion

The 2021 QI Program is based on the Board-approved 2020 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

The revisions are summarized as follows:

1. Updated signature page to reflect Interim Chief Medical Officer Emily Fonda, M.D., Quality Assurance Committee Chair Mary Giammona, M.D., and Board of Directors' Chair Andrew Do

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2. Updated 2020 to 2021 dates throughout program, including up-to-date demographics on membership.

3. Updated Program Initiatives section to initiatives for 2021:
    a. Improve Health Equity and Mitigate Impact: COVID-19 Pandemic
    b. Whole Person Care
    c. Health Homes Program
    d. Homeless Health Initiative
    e. Pharmacy Administration Changes
    f. Virtual Care Strategy

4. Updated Role of CalOptima Officers for QI Program to reflect current organizational roles and responsibilities.

5. Updated 2021 QI Goals and Objectives:
    a. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during the COVID-19 pandemic.
    b. Improve member access to care by 10% from 2019 baseline.
    c. Achieve Accredited NCQA status post 2021 Health Plan Renewal Survey and maintain overall rating at 4.0.

6. Updated language in the Facility Site Review and Medical Record sections to reflect current regulatory descriptions.

7. Moved language related to the description of QI projects standards and documentation from Quality Analytics section to the Population Health Management section.

8. Updated 2021 Delegation Grid to reflect delegated activities consistent with 2020 NCQA Standards, and regulatory requirements.

The recommended changes are designed to better review, analyze, implement and evaluate components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2021 QI Program and QI Work Plan does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

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Concurrence

Board of Directors' Quality Assurance Committee (Anticipated February 25, 2021) Approved 2/25/2021
Gary Crockett, Chief Counsel

Attachments

1. Proposed 2021 Quality Improvement Program and Work Plan (Redline version)
2. Proposed 2021 Quality Improvement Program and Work Plan (Clean version)
3. PowerPoint Presentation: 2021 Quality Improvement Program and Work Plan

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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~~Reviewed by MKC 12-03-20~~

~~2020~~2021

QUALITY IMPROVEMENT PROGRAM

~~2020~~ 2021 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

_____

~~David~~ Emily Fonda~~Ramirez~~, M.D. _____ **Date**
Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

_____

~~Paul Yost~~Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

_____

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~~Paul Yost~~~~Mary Giammona~~Andrew Do~~, M.D.~~

Date

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members ~~is~~ was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration~~:~~

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability~~:~~

We were created by the community, for the community, and are accountable to the community. The following ~~Meetings~~ meetings are open to the public ~~are~~: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect~~:~~

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.

- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (~~OC~~ HCA).
- Substance use disorder services are administered by ~~OC~~ HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including ~~Orange County Health Care Agency (OC~~ HCA~~)~~ and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare ~~benefits~~, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated

services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare ~~benefits~~. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits, and transportation. OCC also includes personalized services through the PCCs to ensure ~~each~~ members receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

Program Initiatives

Mitigate Impact and Improve Health Equity: ~~from~~ COVID-19 Pandemic[SG1][OE2]

The COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE, and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, ~~as well as~~and the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. -Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. -The COVID-19 pandemic shined a ~~blazing~~ bright light on the health disparities and inequity. -The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths~~,~~ but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima ~~has~~ identified opportunities to improve health equity as laid out in its~~the~~ QI ~~w~~Work ~~p~~Plan. -Additionally, the COVID-19 pandemic adversely impacted the mental health of ~~all~~[CM3]-many members, especially ~~for~~ children. -Hence, several trauma-informed interventions ~~will be~~are included in the 2021 QI ~~w~~Work ~~p~~Plan to address the toxic stress and Adverse Childhood Experiences (ACEs~~S~~) related to the COVID-19 pandemic.~~Intervention Team (ACE IT) was developed to provide members who screen positive or at moderate risk level for ACEs access to supportive services, with the goal to help members develop resiliency and minimize negative impact of ACEs on health outcomes.~~

~~Whole-Person Care~~Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017~~–~~2019 Strategic Plan. In Orange County, the pilot is being led by the ~~OC~~ HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. ~~For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.~~ However, WPC ~~is~~was scheduled to terminate on December 31, 2020~~,~~; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition

was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity, rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program, and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implemented HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During the implementation, of HHP,

CalOptima's goal is to targeted the highest risk 3–5% percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing--related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.CalOptima has partnered with the OC HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers that they have been working with for their housing--related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connrrections[SG4][OE5]; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole--Person Care program, recuperative care services provide post-acute care for up to 90- days for homeless CalOptima members:. OC HCA and CalOptima split the cost of recuperative care on a 50/50 basis;. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to OC HCA in connection with the Whole--Person Care program, and the CalOptima Board of Director's has authorizationed tothe extendsion of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.-
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to OC HCA to provides additional respite care beyond the 90 days of recuperative care under the Whole--Person Care program.- These grant funds have been exhausted.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency'sHCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in -person.
-
- Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventative care services and care coordination helps connect the member back to the primary care delivery system.- Community health centers work with nearby shelters and hot spots that meet the program requirements and will receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we will beare able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima will have be able to provides preventive screenings, and chronic care, care coordination, and follow- up.

- ~~The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.~~

- Hospital Discharge Process for Members Experiencing Homelessness—~~-~~Support is provided to assist hospitals with the increased cost associated with discharge planning under ~~new~~ state requirements.

Pharmacy Administration Changes

It is expected that, e~~E~~ffective April 1, 2021, the Department of Health Care Service (DHCS) ~~is~~will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing,~~/~~/ prior authorizations, formulary administration, and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima--retained responsibilities will include physician-administered drug claims processing~~/~~, prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board.– This change is for the Medi-Cal program only, and does not affect the ~~OC/OCC~~OneCare/OneCare Connect, and PACE [SG6][OE7]~~programs~~ lines of business.

Virtual Care Strategy

In 2020~~1~~, ~~the~~ federal and state rules and regulations provided~~ing~~ limited waivers for telehealth due to the COVID-19 pandemic~~,~~ that enabled CalOptima to accelerate its virtual care strategy under COVID-19 shelter--at--home measures. -Members were able to receive appropriate health care services though telephone and video visits. CalOptima plans to continue expanding implementation of various ~~V~~virtual ~~C~~care s~~S~~trategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management~~;~~.

2. Leverage existing delivery model where possible~~;~~.

3. Be proactive in seeking out opportunities to innovate.~~; and~~

4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work ~~p~~Plan. With these ~~V~~virtual ~~C~~care ~~S~~strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. ~~1)~~ Improved member access and convenience.

2. ~~; 2)~~ Reduced avoidable in-person visits to specialists.~~; and 3)~~
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as: ~~I~~improved member experience~~;~~, ~~A~~augmented network capacity and adequacy~~;~~, and ~~I~~improved clinical quality outcomes.

~~*Behavioral Health for OC/OCC*~~

~~CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1,2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.~~

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima ~~H~~health n~~N~~etwork (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. ~~Members enrolled in CalOptima Direct-Administrative are not HN- eligible.~~

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. – CCN is administered directly ~~internally~~ by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for ~~growth~~access.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)

- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following ~~13 Hheath Nnetworks~~HNs[SG8][OE9]:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	~~SRG~~	~~SRG~~
Family Choice Medical Group		SRG	SRG
~~Heritage~~ HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch ~~Family~~ HealthCare	~~HMO~~	SRG	~~HMO~~
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan~~Medical Group~~	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management ~~(UM)~~
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer S~~s~~ervice~~s~~ activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

[OE10]

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the ~~Centers for Medicare & Medicaid Services (~~CMS~~)~~ Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program—and in collaboration with its providers and community partners—CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA and meet DHCS/CMS quality ~~requirements~~ and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- ~~Sets~~ Setting expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes.~~.~~
- ~~Supports~~ Supporting the provision of a consistent level of high quality ~~of~~ care and service for members throughout the contracted provider networks, as well as ~~monitors~~ monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers.~~.~~
- ~~Provides~~ Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

  ~~Ensures~~ Ensuring certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority ~~OC~~ HCA which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.~~, as reported by the HNs~~[SG11]~~.~~
- ~~Promotes~~ Promoting patient safety and ~~minimizes~~ minimizing risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and ~~works~~ working with appropriate committees, departments, staff, practitioners, provider medical groups~~,~~ and other related O~~o~~rganizational P~~p~~roviders (~~OPS~~OPs) to assure that steps are taken to resolve and prevent recurrences.
- ~~Educates~~ Educating the workforce and ~~promotes~~ promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes ~~apply to populations served~~are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD-A network providers serving CalOptima's various populations~~, to~~:

- Support~~ing~~ the agency's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently~~.~~
- ~~The c~~Continuously improve~~ingment of~~ clinical care and service~~s~~ quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population~~.~~

- ~~The t~~Timely identifying ~~ication of~~ important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high- risks, and disease profiles for both acute and chronic illnesses, and preventive care~~.~~
- ~~The~~ Ensuring continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities~~.~~
- ~~The~~ Ensuring accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population~~.~~
- ~~The~~ Monitoring the qualifications and practice patterns of all individual providers in the network to deliver quality care and service~~.~~
- ~~The~~ Promoting the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances~~.~~
- ~~The~~ Ensuring the reliability of risk prevention and risk management processes~~.~~
- ~~The~~ Ensuring compliance with regulatory agencies and accreditation standards~~.~~
- ~~The accountability cadence of~~Ensuring the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans~~.~~
- ~~The~~ Promoting the effectiveness and efficiency of internal operations~~.~~
- ~~The~~ Ensuring the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs~~.~~
- ~~The~~ Ensuring the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values~~.~~
- ~~The~~ Ensuring compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES~~,~~ AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's s~~S~~tate and f~~F~~ederal ~~C~~contracts — and to CalOptima's Chief Executive Officer (CEO), as ~~discussed~~ described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify ~~the~~ member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with ~~F~~federal and ~~S~~state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and ~~review and~~ make recommendations to the Board regarding ~~accepting~~ the overall QI Program. QAC ~~and annual evaluation, and~~ routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives~~,~~ and ~~improvements~~quality performance results achieved. The QAC also makes recommendations to the Board for ~~for~~ annual approval with modifications and appropriate resources allocations of the QI Program ~~and actions~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim~~, moving upstream from the~~(which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation~~,~~ and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preven~~ta~~tative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons ~~—~~ ~~M~~medical ~~S~~safety ~~N~~net
- ~~OC HCA~~
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs ~~—~~ ~~B~~behavioral/~~M~~mental ~~H~~health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by ~~OC~~ HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and ~~C~~c~~C~~ommunity-~~B~~b~~B~~ased ~~S~~s~~S~~ervices [SG12](HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
  - HCA, Behavioral Health
  - OC SSA
  - OC Community Resources Agency, Office on Aging
  - ~~OC HCA, Behavioral Health~~
  - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent ~~a~~ the broad provider community that serves CalOptima members. The PAC ~~is comprised of~~has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of ~~OC~~ HCA, which maintains a standing seat. PAC meets at least quarterly and ~~are~~ is open to the public. The 15 seats include:

- ~~HN~~ Health networks
- Hospitals
- Physicians (three ~~3~~ seats)
- Nurse
- Allied health services (~~2~~two seats)
- Community health centers
- ~~OC~~ HCA (~~1~~one standing seat)
- LTSS (LTC facilities and CBAS) (~~2~~ ~~1~~one seat~~s~~)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

~~In 2018, CalOptima's Board of Directors established the~~ Whole-Child Model Family Advisory Committee (WCM FAC), ~~a~~~~is~~has been required by the state as part of California Children's Services (CCS) ~~when~~since it bec~~o~~am~~e~~~~ing~~ a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: ~~7 9~~seven to nine seats

    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are ~~a~~ current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
    - ~~o~~
- Interests of children representatives: ~~2 to~~ 4two to four seats
    - Community-based organizations; or
    - Consumer advocates

Members of the c~~C~~ommittee shall serve staggered two-year terms. ~~Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term.~~ WCM FAC meets at least quarterly and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the s~~S~~tate and f~~F~~ederal ~~Contracts~~contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) —oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met.– The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care practitioner in the QI program who~~, and~~ serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC.~~–~~ The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED ~~of~~ Q&PHM) is responsible for facilitating the company~~-~~wide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED ~~of~~ Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED ~~of~~, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED ~~of~~ Q&PHM are the~~:~~ Directors of~~,~~ Quality Analytics~~,~~; ~~Director,~~[CM13] Quality Improvement~~;~~, ~~Director,~~ Population Health Management~~;~~, ~~Director,~~ Behavioral Health Services (Clinical Operations)~~;~~ and ~~Director,~~ Behavioral Health Integration.

Executive Director, Clinical Operations (ED ~~of~~ CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including~~:~~ UM, Care Coordination, Complex Case Management, LTSS and MSSP ~~S~~services, along with new program implementation related to initiatives in these areas. The ED ~~of~~ CO serves as a member of the executive team~~,~~ and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED ~~of~~ PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED ~~of~~ PI are the directors of both Process Excellence and ~~: Director, Process Excellence; and Director,~~ Strategic Development.

Executive Director, Compliance (ED ~~of~~ C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs~~,~~ and other functional areas. The ED ~~of~~ C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED ~~of~~ C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to s~~S~~tate and ~~F~~federal requirements.

Executive Director, Network Operations (ED ~~of~~ NO) leads and directs the integrated operations of the HNs~~,~~ and must coordinate organizational efforts internally~~, as well as~~ and externally~~,~~ with members, providers and community stakeholders. The ED ~~of~~ NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED ~~of~~ O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, ~~Government~~ Public Affairs (Chief of Staff) ~~(New)~~ is responsible for the oversight and measurement of CalOptima's communications, legislative, community relations~~,~~ and strategic development programs.~~ –~~ The ~~eChief of Sstaff~~ED ~~of~~ PA ~~will~~ assists the CEO in carrying out organizational goals~~,~~ and ~~will~~ planning, developing and implementing strategies to effectively communicate and implement the CalOptima mission with internal and external contacts, including employees, the public, members, providers, government officials, and the media.

~~Add JD~~

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, t~~T~~he QIC oversees ~~in collaboration with the Compliance Committee~~ the performance of delegated functions ~~by monitoring~~by monitoring its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes ~~a~~ participating practitioners ~~that~~who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed~~,~~ and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include ~~the following~~:

- ~~Recommends~~ Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- ~~Oversees~~ Overseeing the analysis and evaluation of QI activities.
- ~~Makes~~ Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation, and review of QI program activities.

- ~~Identifies~~ Identifying and ~~prioritizes~~ prioritizing needed actions and interventions to improve quality.
- ~~Makes~~ Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners, and delegated health networks are evaluated, such as UM over/under utilization in collaboration with ~~ABA~~applied behavioral analysis utilization, and recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with ~~4~~ four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data ~~and~~ collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter~~,~~ and includes, but may not be limited to~~, the following~~:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration

- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year~~,~~ and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code §-14087.58(b), Health and Safety Code §-1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the c~~C~~ommittee ~~C~~chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of W~~w~~ork ~~p~~Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process,~~;~~ and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates, and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues

and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate~~,~~ and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its ~~program~~ lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-~~011~~023. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations, and referrals for the "pain points" in health care that impact our members. In 202~~0~~1, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least ~~bi-monthly~~quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2021~~0~~ and MY 2022~~1~~ CAHPS survey results.

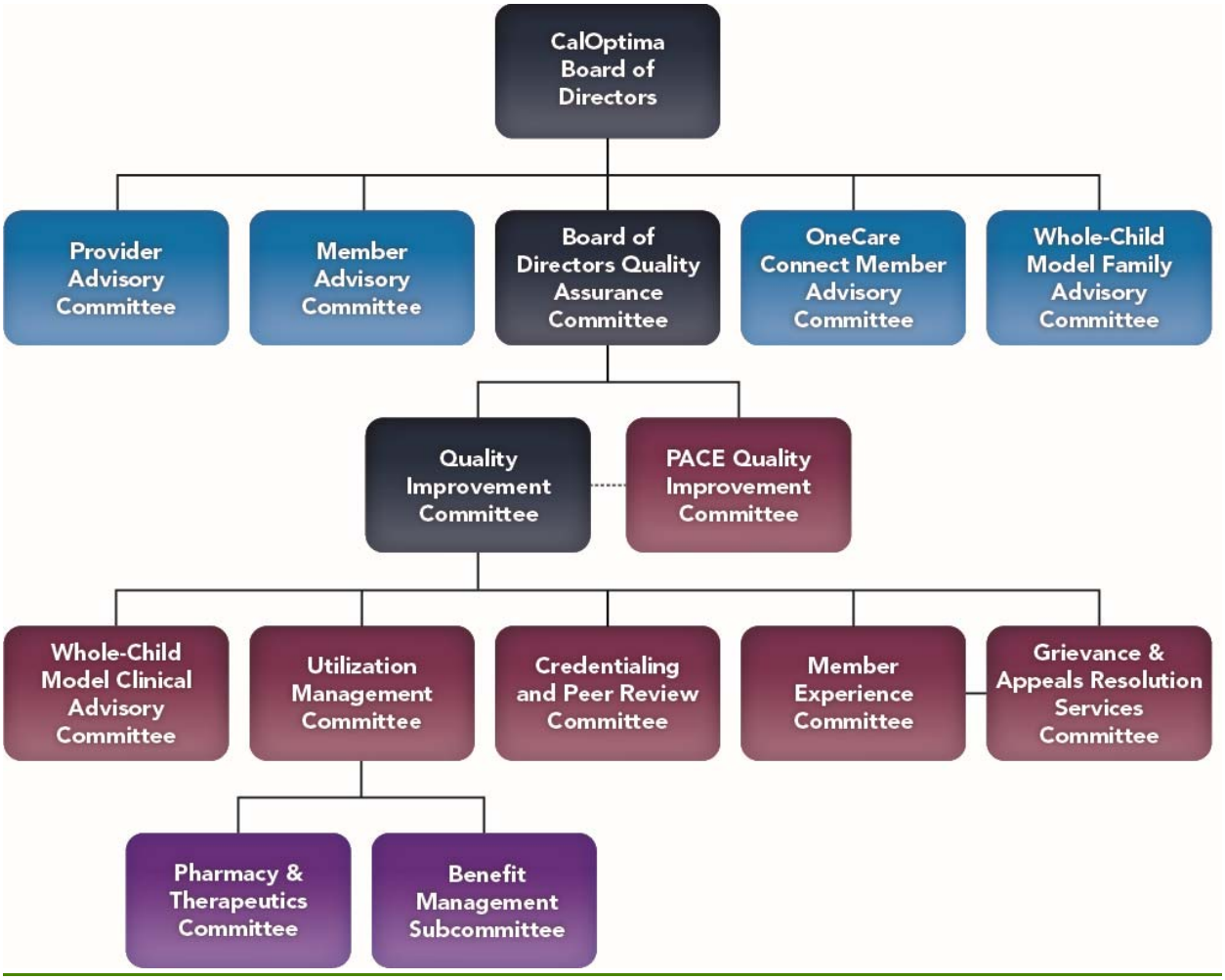
Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)

The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

~~2020~~ Committee Organization Structure — Diagram



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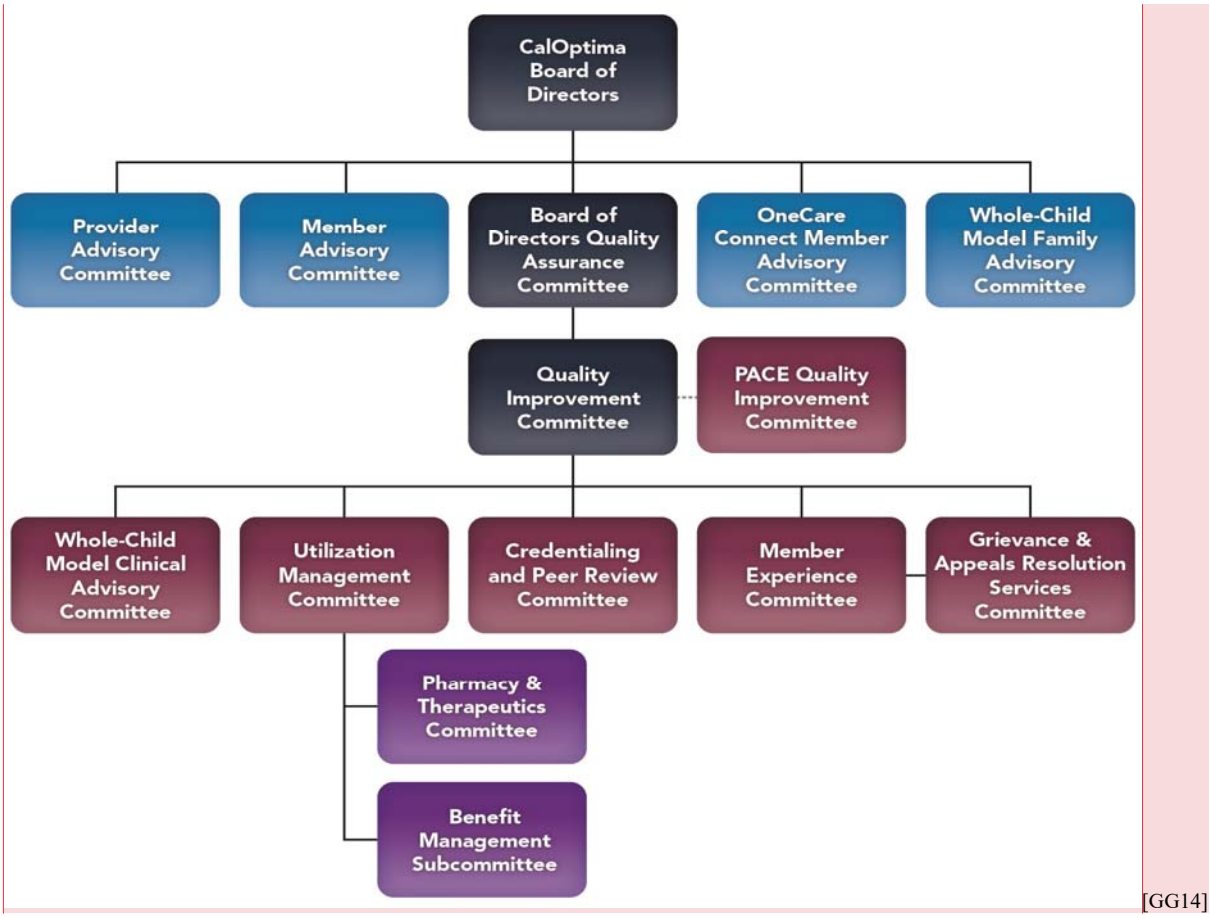

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Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees—including contracted professionals who have access to confidential or member information—sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

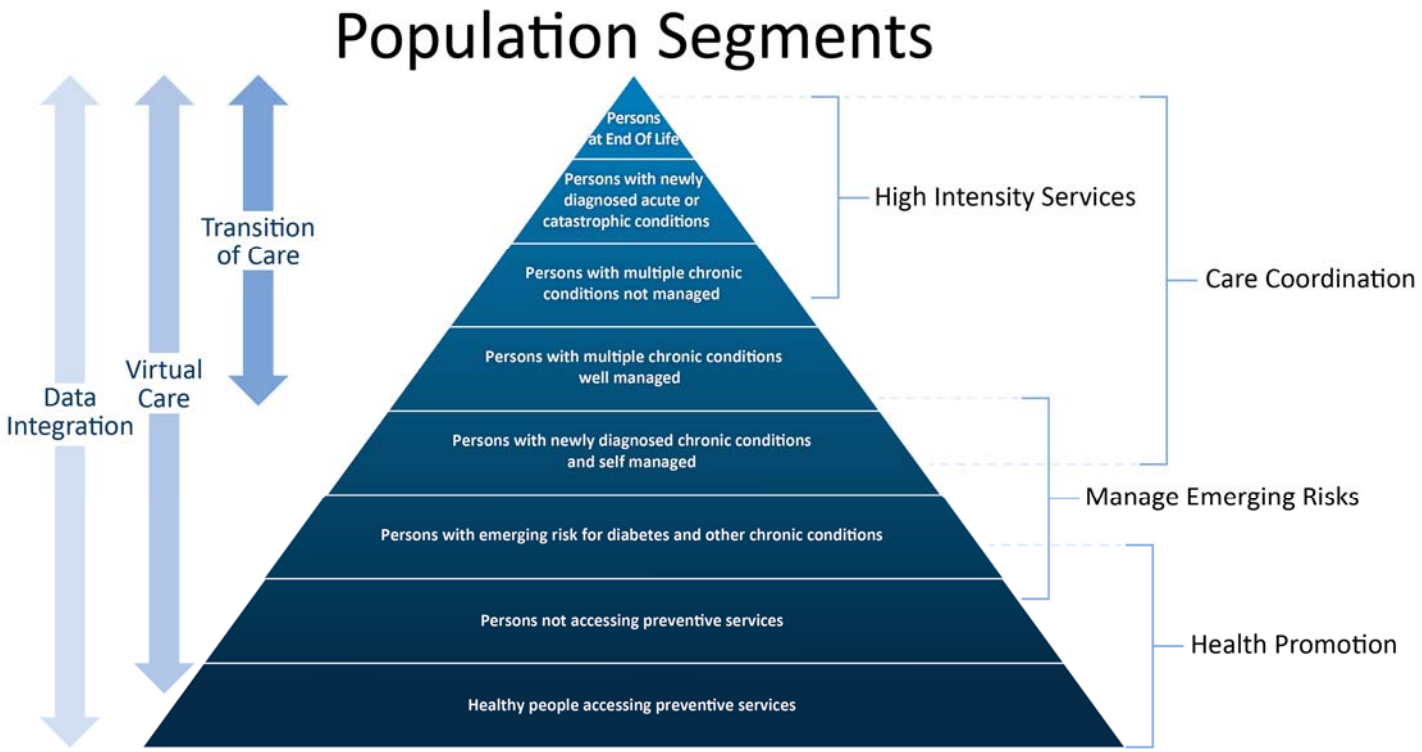
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure ~~supports~~ provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by~~,~~ stratifying the~~our~~ population based on their health needs, conditions, and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2021~~0~~ QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



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CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one- by- one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

20210 QI Goals and Objectives[SG15][OE16]

CalOptima's QI Goals and objectives are aligned with CalOptima's 20210–20221 Strategic goals.

1. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.

2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.

1.3. Achieve Accredited NCQA status post 2021 Renewal Survey, and mMaitainMaintain Increase NCQA overall rating from at 4.0 to 4.5
Improve

These top three priority goals were chosen to be aligned with CalOptima's strategic objectives related to the pandemic, as well as continued goals related to access to care and NCQA Accreditation. The 2021 QI Workplan details the planned activities to meet the COVID-19 vaccine aim which include an immunization strategy, a targeted communication strategy and a member incentive strategy. The planned activities related to member's ability to access care are captured in the Virtual Care strategy as well as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). Finally, the goal of achieving NCQA---Accredited status in 2021 and maintaining the overall health plan rating is a high priority since CalOptima will be pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

1. Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly
1. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

Detailed strategies for achieving 2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima ~~the~~ strategic priorities and the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the s~~S~~tate or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities

- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual patient care ~~to aid~~aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2021 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2021~~0~~ QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.
- Measures required by regulators, such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement~~,~~ and ~~is occurring~~occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority~~, which~~ that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance~~,~~ (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, ~~M~~management, QIC, UMC, etc., based upon the scope of work and impact of the effort.
- These improvement efforts are often cross~~-~~-functional~~,~~ and require dedicated resources to assist in data collection, analysis~~,~~ and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality M~~m~~easures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers~~,~~ or predictors of the desired outcome measures or lag quality measure, such as HEDIS and ~~STARS~~ Stars measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN~~s~~, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. ~~See explanation of Clinical Data Warehouse below.[SG17]~~

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with ~~5–10~~5–10% ~~percent~~ over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411~~,~~ and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% ~~percent~~ of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depend~~ent~~ing on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI ~~w~~Work ~~p~~Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors,– through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forums, and other ongoing ad -hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both web-site and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes, and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on ~~the our~~CalOptima's website, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation, and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED, ~~of~~ Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED ~~of~~, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - QI Nurse Specialists
  - Program Policy Analyst
  - Credentialing Coordinators
  - Program Specialists (including Intermediate and Senior)
  - Program Assistants
  - Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics Network Adequacy Manager
  - Quality Analytics Data Analytics Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management

Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dietietians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health Integration
pProvides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration Ddepartment efforts in integrated care, quality initiatives, and community partnerships. The Ddirector ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operations)
pProvides clinical operational oversight and leadership to the implementation, expansion, and/or improvement of processes and services s of the Behavioral Health Integration dDepartment clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and ~~utilization management~~UM for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management
A assists in the development and implementation of the UM program, policies, and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective, and retrospective reviews that support UM medical management decisions, serves

on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management
~~l~~Leads the development and implementation of the Pharmacy Management (PM) program, develops, and implements PM department policies and procedures,~~;~~ ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of ~~P~~pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics ~~c~~Committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
R~~is r~~esponsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports
~~is r~~Responsible for LTSS programs, which include CBAS, LTC~~,~~ and MSSP. The position supports a ~~"Member Centric"~~member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures~~,~~ and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics
~~p~~Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and ~~roadmap~~road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the ~~roadmap~~road map. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the ~~e~~Enterprise ~~a~~Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job-~~-~~specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)

- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training
- ~~QI Lean training curriculum (added to CalOptima University in 2019)~~

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization, and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC~~,~~ and QAC~~,~~ and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.

- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors' review and approval.

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care, and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM and CM Programs and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight

- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

** CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety and quality--related activities.
  - Drive improvement of quality of care received.
  - Minimize rework and unnecessary costs.
  - Measure the member experience of accessing and getting needed care.
  - Empower staff to be more effective.
  - Coordinate and communicate organizational information, both division and department-specific, as well as agency-wide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agency-wide practices that support accreditation and meet~~ing~~ regulatory requirements.

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to

CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following:, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to:, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and delegated to HNs and other sub-delegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and re-credentialing of organizational providers (OPs) such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with sState and Ffederal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Ffederal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care ~~practitioner~~ provider (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR, and physical accessibility review survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% ~~percent~~ on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with MMCD Policy Letter 14-004 and CalOptima policies. The Initial Medical Record Review shall be completed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR, and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.
~~Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full-scope site review performed by another health plan in the past three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.~~

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room

- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that its contracted delegated HNs make certain that each member's~~'~~ medical record is maintained in an accurate manner that is current, detailed, organized and easily accessible to treating practitioners. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.~~–~~ All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care~~,~~ in such a way that it facilitates communication, coordination and~~,~~ continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by ~~S~~state and ~~F~~federal laws and regulations, and the requirements of CalOptima's contracts with CMS~~,~~ and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable ~~F~~federal and ~~S~~state law.

~~**CalOptima requires that its contracted delegated HNs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.**~~

~~The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, and DHCS.~~

~~The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.~~

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the ~~appropriate~~ relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance

Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.
- ~~Identification and reporting of medical disciplinary cause or reason issues to the appropriate state board.~~[SG18]
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- ~~Prescribed continuing education or office training~~
- ~~De-delegation~~
- ~~De-credentialing~~
- ~~Contract termination~~[SG19][OE20]

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.

- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider--specific performance on quality metrics, as required.
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners.
- Facilitate satisfaction surveys for members. and[CV21] practitioners.
- Provide agency-wide oversight of monitoring activities that are:
  - Balanced: Measures clinical quality of care and customer service
  - Comprehensive: Monitors all aspects of the delivery system
  - Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case mManagement reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data, and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARStars and HOS measures. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping mMembers Hhealthy
2. Managing Mmembers with eEmerging rRisks
3. Patient Ssafety or Ooutcomes Aacross Ssettings
4. Managing Mmultiple Cchronic Cconditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, andwhich was adopted again in 2020. The 2019 PHM Strategy will continue into 2021,0 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&Lcultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct Qquality Iinitiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. QQuality Iinitiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 20210 are tracked in the QI Work Pplan and reported to the QIC.

In 20210, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services, and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions.

Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member--focused trauma informed care to be consistent with NCQA ~~2020~~ Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma--Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The ~~population health management~~PHM team also focuses on improvement projects such as QIP's, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

~~Interventions~~

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member--specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. ~~A.~~ Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. ~~B.~~ Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source, and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agency-wide ~~population health~~ PHM programs**.** PHM programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members, and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management, ~~and~~ Tobacco Cessation, Asthma, Immunizations, and Well Child Visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources, and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, ~~that~~which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner, and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of social determinates of health (SDOH). It proactively identifies those members in need of closer management, coordination, and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC, and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination, and basic are specific to SPD, OCC, and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP

        - Communication with members or their representatives, vendors, and medical group
        - Review and update the ICP at least annually, and when there is a change in the member's health status
        - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - ~~Meets~~ Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization

- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and ~~at~~ at high-risk individuals
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy,

psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated~~,~~ to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including ~~utilization management~~UM, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC

~~CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1~~In~~,~~ 202~~1~~0, OC/OCC behavioral health ~~will~~ continues to be ~~be~~ fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician, or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2021~~0~~ UM Program Description. ~~and related Work Plan.~~

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and ~~roadmap~~road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved, and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture, and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results~~;~~, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings, including CBAS, SNF, and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, critical incident identification, appropriate investigation, and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 Infection Prevention and Protective Equipment
  - MRSA prevention program (Shield)
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact~~;~~, 24-hour access to telephonic interpreter services~~;~~, member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, ~~PDF~~ or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- OC member materials are provided in three languages: English, Spanish and Vietnamese.
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services

- QI program for all lines of business~~,~~ (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards).
- Behavioral Health for MC, OC, and OCC lines of business
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, and peer review process on specific, referred cases
- Development of system-wide measures, thresholds, and standards
- Satisfaction surveys of members, practitioners, and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and ~~health care delivery~~ organizational providers (OPs)~~rganizations OP~~[SG22][OE23]
- Credentialing and re-credentialing of OPs~~of OPs~~[SG24]
- Development of UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2021~~0~~ Delegation Grid.

See Appendix B — 2021~~0~~ Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

Appendix A — 2021~~0~~ QI Work Plan

APPENDIX B — 2021~~0~~ DELEGATION GRID

APPENDIX C — ~~QI~~ ORGANIZATIONAL CHART

2021 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2021 QI Annual Oversight of Program and Work Plan
B. 2020 QI Program Evaluation
C. 2021 UM Program
D. 2020 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program updates (Health Network Quality Rating, MCAS, P4V)
M. Improvement Projects (All LOB)
QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC
N. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
O. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
P. Homeless Health Initiatives (HHI): Health Homes Program Phase 2
Q. Health Equity

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted to Board of Director's: Date:

Quality Improvement Committee Chairperson:

Emily Fonda, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, MD Date:

B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
C. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*, which is a NCQA Accreditation Measure

D. Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations
B. Blood Lead Screening

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Virtual Care Strategies

VIII. QUALITY OF SERVICE- Member Engagement

A. Improve Member Experience- Member Engagement

IX. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure.
   OCC Quality Withhold measure.
B. Quality of Care Grievances and Potential Quality Issue
   (GARS/PQI) Processing
C. Post-Acute Infection Prevention Quality Incentive (PIPQI)
D. Orange County COVID Nursing Home Prevention Program.

E. LTC Facility Transfer Plan due to COVID-19

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT								
2021 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2021 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by February 2021	Betsy Ha				
2020 QI Program Evaluation	Complete Evaluation 2020 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by February 2021	Betsy Ha				
2021 UM Program	Obtain Board Approval of 2021 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by February 2021	Mike Shook				
2020 UM Program Evaluation	Complete Evaluation of 2020 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by February 2021	Mike Shook				
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Pshyra Jones				
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima				
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Ana Aranda				
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook				
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD				
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital				
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V). Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital				
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures- Due March 2nd. **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo/Cathy Osborn				
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achive program milestones quarterly and annual performance goals	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Quarterly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Quarterly Adoption of Report	Edwin Poon				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Sloane Petrillo				
Homeless Health Initiatives (HHI): Health Homes Program Phase 2	Improve Health & Access to care for enrolled members	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI 5. Focus on telephonic outreach d/t COVID-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Quarterly Report	Sloane Petrillo				
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Pshyra Jones/Betsy Ha/Marie Jennis				
II. QUALITY OF CLINICAL CARE- Adult Wellness								
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	**MY2020 Goal:** **CCS -** MC 60.65% **COL** - OCC 73%, OC 62% **BCS** -MC 58.67%, OCC - 76%, OC - 76%	1) Continue $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Track the number of mammograms scheduled through targeted outreach. 4) Member Health Rewards RFP and Vendor Contract	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (16 and over).	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a.They are now eligible to be vaccinated. b.Where they need to go to be vaccinated (when available) c.This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health								
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2020 Goal:** 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:18.20 %	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	12/31/2021	Edwin Poon	Yes			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**MY2020 Goal:** MC - Init Phase - 43.41% MC -Cont Phase - 55.05%	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	12/31/2021	Edwin Poon	Yes			
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS MY2020 Goal:** **MC:NA**	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	12/31/2021	Edwin Poon	Yes			
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 41% OC 56% OCC 56%	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	12/31/2021	Edwin Poon	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE- Chronic Conditions								
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**HEDIS MY2020 Goal: (A1C Poor Control)** MC:37.47% OC: 19.46% OCC: 19.46%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Member Health Rewards RFP and Vendor Contract 3) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS MY2020 Goal: (Diabetric Eye Exams)** MC: 58% OC: 67.5% OCC: 67.5%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
V. QUALITY OF CLINICAL CARE- Maternal Child Health								
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	**HEDIS MY2020 Goal:** Prenatal 83% Postpartum 65%	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	12/31/2021	Ann Mino	Yes			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness								
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	**HEDIS MY2020 Goal:** MC 68.37%	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Blood Lead Screening	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2020 Goal**: Lead Screening 50th percentile 73.11%	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials, 4) Prop 56 provider value based payments for Blood Lead Screening	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access								
Improve Access: Reducing gaps in provider network	Contract with a minimum of 25% of targeted providers identified by the network adequacy work group.	1) Actively recruit hard to access specialties for CCN	12/31/2021	Michelle Laughlin/Jennifer Bamberg				
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists by 10 percentage points.	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After All Attempts** from 28.3% to 25.0%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Virtual Care Strategies	Increase telehealth utilization rate from 24.1% to 30% (visit count/# members) Increase member telehealth usage from 8.8% to 10% (teleheatlh member count/# members)	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	12/31/2021	Marsha Choo/Rick Cabral				
VIII. QUALITY OF SERVICE- Member Engagement								
Improve Member Experience: Member Engagement	Increase member engagement via member portal.	1) Member Portal 2) Member Outreach Calls	12/31/2021	Mauricio Flores/Andrew Tse				
IX. SAFETY OF CLINICAL CARE								
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2020 Goal**: MC - NA OC 8%;OCC 0.85 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	12/31/2021	Mike Shook	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	Provide clinical recommendations to members with a quality of care grievance within 30 days.	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	12/31/2021	Laura Guest/Ana Aranda				
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2021	Cathy Osborn/Scott Robinson	Yes			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COVID-19 as soon as possible 2) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COVID 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www.ucihealth.org/stopcovid	5/31/2021	Cathy Osborn/Scott Robinson				
LTC Facility Transfer Plan due to COVID-19	Transfer 100% of CalOptima members to other facilities within 5 days of evacuation notice.	1) Train all LTSS staff in LTC operational DTP: LTC015 LTC facilities planned and unplanned closure process. 2) Monitor all nursing facilities for COVID_19 positive rates in members and facility staff 3) Identify high-risk facilities that hae COVID-19 related staffing shortages and high infection rates that my require evacuation. 4) Identify and maintain a log of available nursing facility beds that members could be transferred to.	12/31/2021	Scott Robinson				

APPENDIX B — 2021 DELEGATION GRID

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.2.4	PHM2D: Segmentation-PHM	X		X	
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X		X	
3.4.2	NET4B: Continued Access to Practitioners	X		X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA for Interim Surveys only
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				NA for Medicaid
4.9.6	UM9F: Appeals Overturned by the IRO				NA for Medicaid
4.9.7	Provider Appeals Provider Complaint Processing	X	X	X	
4.10.1	UM10A: Written Process				NA for Medicaid
4.10.2	UM10B: Description of the evaluation Process				NA for Medicaid
4.11.1	UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X	
4.11.2	UM11B: Pharmaceutical Restrictions/Preferences	X		X	
4.11.3	UM11C: Pharmaceutical Patient Safety Issues	X		X	
4.11.4	UM11D: Reviewing and Updating Procedures	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.11.5	UM11E: Considering Exceptions	X		X	
4.12.1	UM12A: UM Denial System Controls	X	X	X	
4.12.2	UM12B: UM Appeal System Controls	X		X	
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				NA due to Carve out
5.7.4	CR7D: Assessing Medical Providers	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.5	CR7E: Assessing Medical Providers				NA due to Carve out
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations				NA for Medicaid
6.3.2	ME3B: Communication with Prospective Members				NA for Medicaid
6.3.3	ME3C: Assessing Member Understanding				NA for Medicaid
6.4.1	ME4A: Functionality: Website	X		X	Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X		X	Not Required for Renewal Survey

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			May not be Delegated
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Claims Processing Timeliness of Claims and Interest on Late Claims	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR)	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
7.1.7	Third Party Liability (TPL) CalOptima policy FF.2007: Reporting of Potential Third-Party Liability.	X	X	X	
7.1.8	Family Planning Services CalOptima Policy GG.1118: Family Planning Services, Out-of-Network	X	X	X	

Note: NCQA Elements are based on current 2020 HP Standards.

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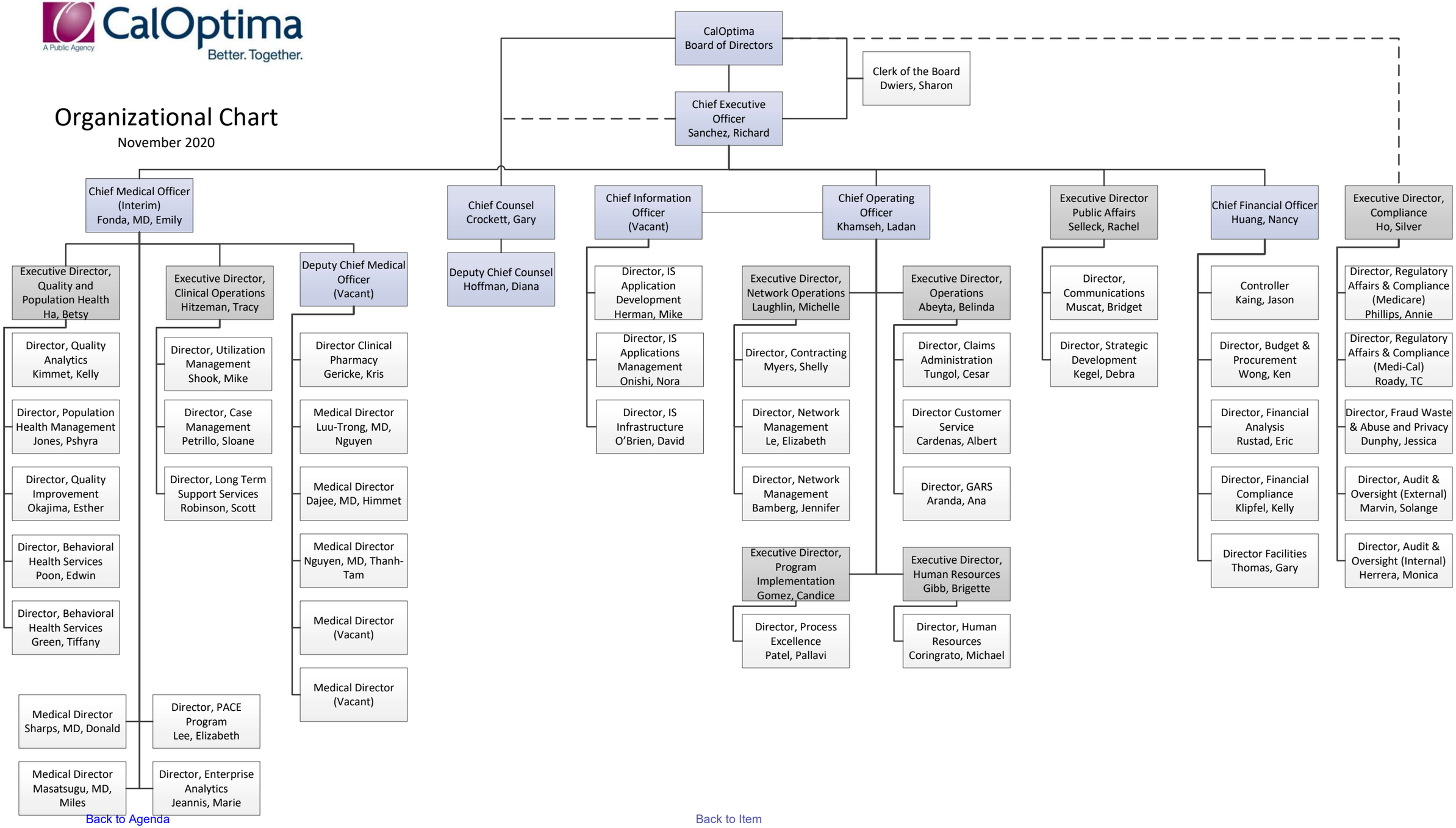
APPENDIX C — ORGANIZATIONAL CHART

CalOptima
A Public Agency
Better. Together.

Organizational Chart

November 2020



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CalOptima
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2021

QUALITY IMPROVEMENT PROGRAM

2021 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Emily Fonda, M.D. **Date**
Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Mary Giammona, M.D. **Date**

Board of Directors Chair:

Andrew Do **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. The following meetings are open to the public: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits, and transportation. OCC also includes personalized services through the PCCs to ensure members receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

Program Initiatives

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE, and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, and the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. WPC was scheduled to terminate on December 31, 2020; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity, rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program, and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD) and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing-related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers for their housing-related services.

Homeless Health Initiative (HHI)

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

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole-Person Care program, recuperative care services provide post-acute care for up to 90 days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with the Whole-Person Care program, and the CalOptima Board of Directors has authorized the extension of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.

- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole-Person Care program. These grant funds have been exhausted.

- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in person.

  Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima provides preventive screenings, chronic care, care coordination, and follow up.

- Hospital Discharge Process for Members Experiencing Homelessness—Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

It is expected that, effective April 1, 2021, the Department of Health Care Service (DHCS) will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing, prior authorizations, formulary administration, and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will

include physician-administered drug claims processing, prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only, and does not affect the OneCare/OneCare Connect, and PACE lines of business.

Virtual Care Strategy

In 2020, federal and state rules and regulations provided limited waivers for telehealth due to the COVID-19 pandemic that enabled CalOptima to accelerate its virtual care strategy under COVID-19 shelter-at-home measures. Members were able to receive appropriate health care services though telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.

2. Leverage existing delivery model where possible.

3. Be proactive in seeking out opportunities to innovate.

4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as: improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County.

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following HNs:

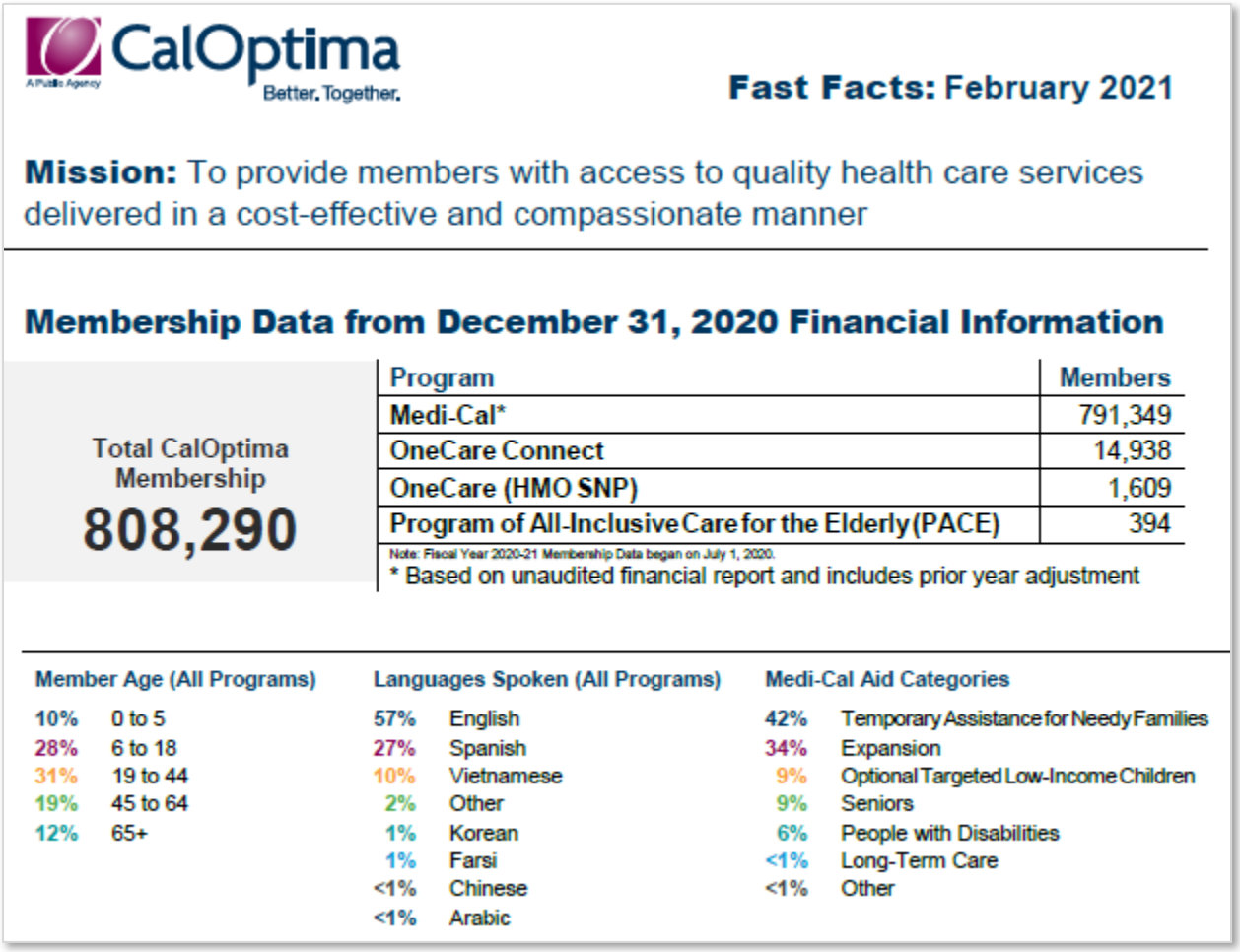
Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	

Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer service activities

MEMBERSHIP DEMOGRAPHICS



CalOptima
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Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the CMS Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program—and in collaboration with its providers and community partners—CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.

- Maintain agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes.

- Supporting the provision of a consistent level of high quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers.

- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

  Ensuring certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority—HCA—which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.
- Promoting patient safety and minimizing risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related Organizational Providers (OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD-A network providers serving CalOptima's various populations:

- Supporting the agency's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently

- Continuously improving clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population

- Timely identifying important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high risks, and disease profiles for both acute and chronic illnesses, and preventive care

- Ensuring continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities

- Ensuring accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population

- Monitoring the qualifications and practice patterns of all individual providers in the network to deliver quality care and service

- Promoting the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances

- Ensuring the reliability of risk prevention and risk management processes

- Ensuring compliance with regulatory agencies and accreditation standards

- Ensuring the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans

- Promoting the effectiveness and efficiency of internal operations

- Ensuring the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs

- Ensuring the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values

- Ensuring compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's state and federal contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with federal and state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation and evaluation of the

overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons — medical safety net
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs — behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - OC SSA

- OC Community Resources Agency, Office on Aging
- OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent the broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC), has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: seven to nine seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are current recipients of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives: two to four seats

- Community-based organizations; or
- Consumer advocates

Members of the committee shall serve staggered two-year terms. WCM FAC meets at least quarterly and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care practitioner in the QI program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED,

Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the EDQ&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Case Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI are the directors of both Process Excellence and Strategic Development.

Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to state and federal requirements.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and must coordinate organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Public Affairs (Chief of Staff) is responsible for the oversight and measurement of CalOptima's communications, legislative, community relations and strategic development programs. The ED PA assists the CEO in carrying out organizational goals and planning, developing and implementing strategies to effectively communicate and implement the CalOptima mission with internal and external contacts, including employees, the public, members, providers, government officials, and the media.

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- Overseeing the analysis and evaluation of QI activities.
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation, and review of QI program activities.
- Identifying and prioritizing needed actions and interventions to improve quality.
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners, and delegated health networks are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization, and recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code §14087.58(b), Health and Safety Code §1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of Work Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates, and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of

application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-023. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations, and referrals for the "pain points" in health care that impact our members. In 2021, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2021 and MY 2022 CAHPS survey results.

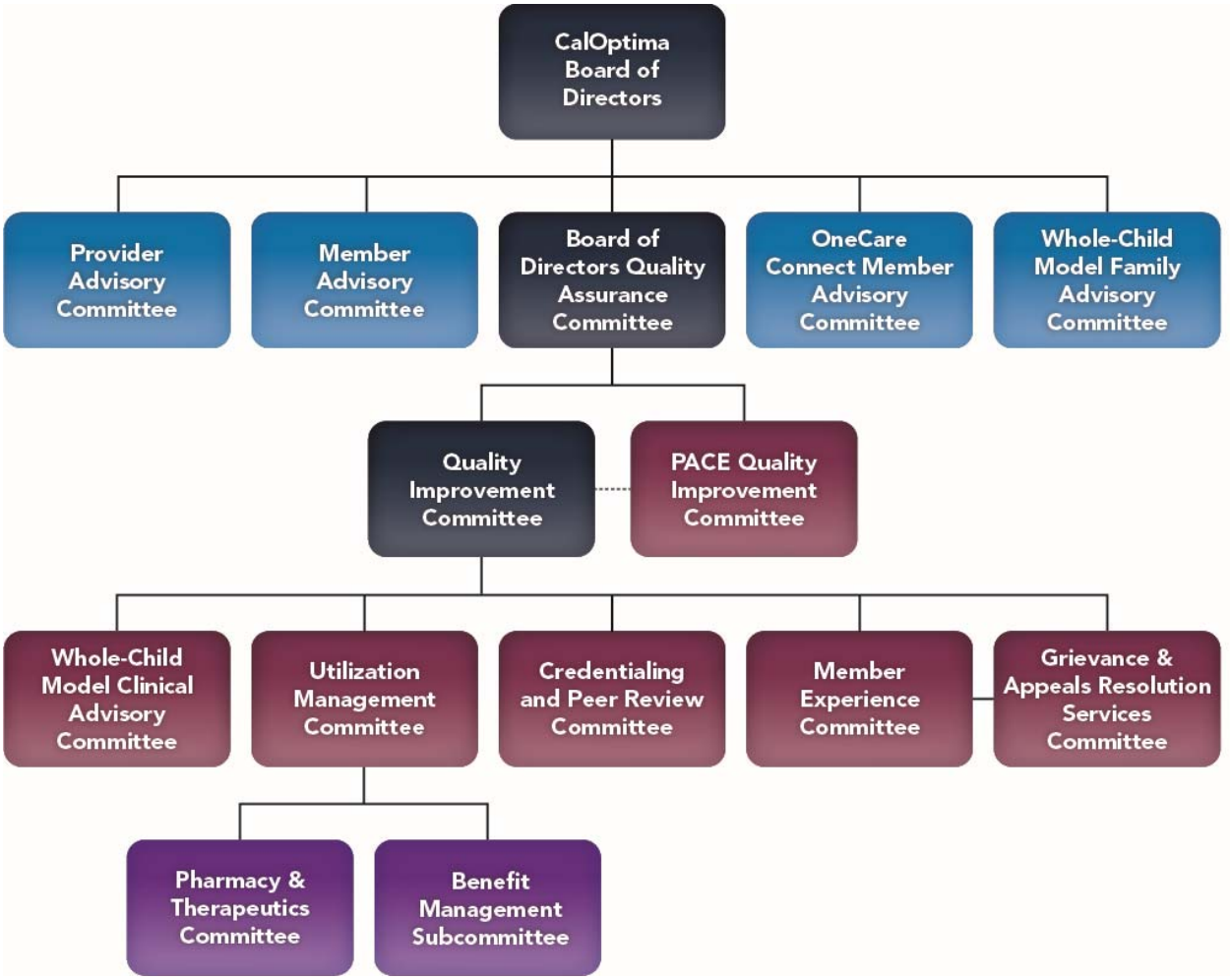
Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)

The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

Committee Organization Structure — Diagram



Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees—including contracted professionals who have access to confidential or member information—sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

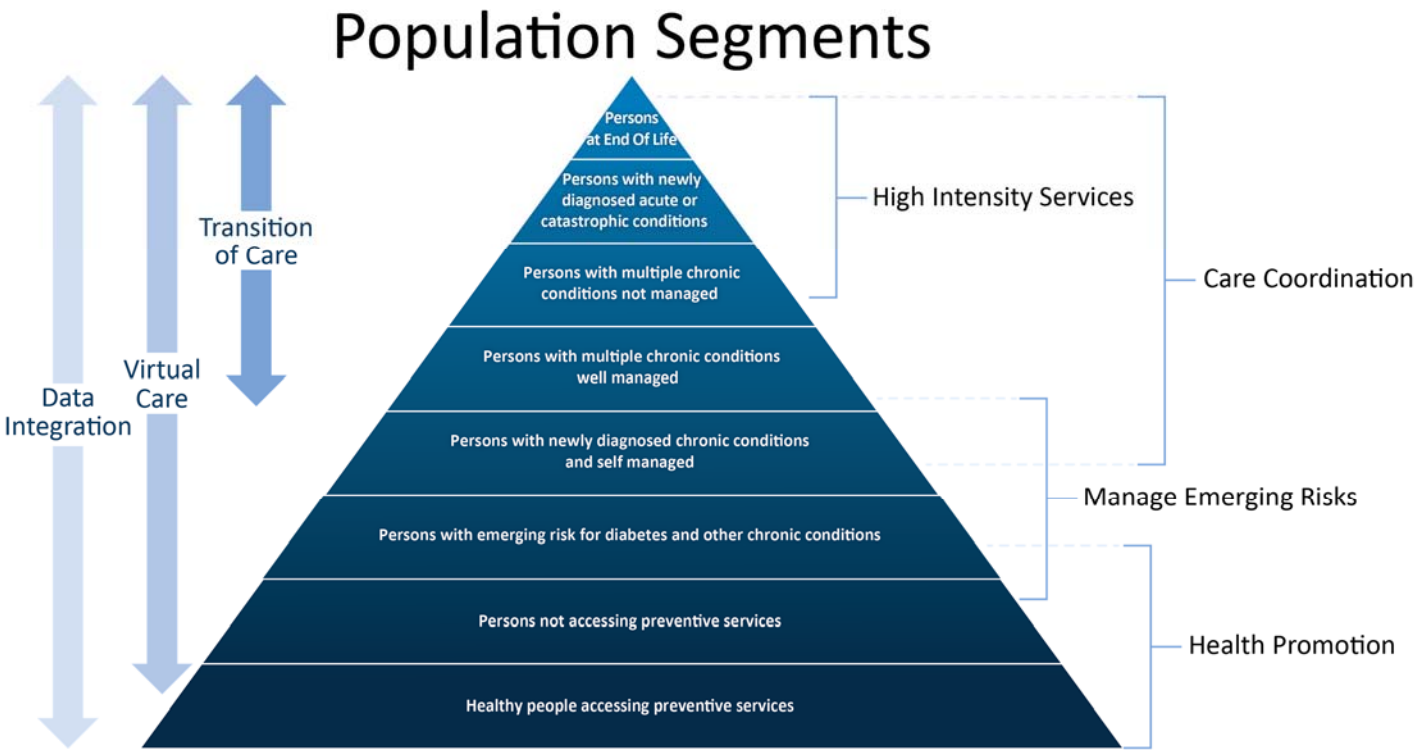
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the population based on their health needs, conditions, and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2021 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2021 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2021–2022 Strategic goals.

1. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.

2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.

3. Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0

These top three priority goals were chosen to be aligned with CalOptima's strategic objectives related to the pandemic, as well as continued goals related to access to care and NCQA Accreditation. The 2021 QI Workplan details the planned activities to meet the COVID-19 vaccine aim which include an immunization strategy, a targeted communication strategy and a member incentive strategy. The planned activities related to member's ability to access care are captured in the Virtual Care strategy as well as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). Finally, the goal of achieving NCQA-Accredited status in 2021 and maintaining the overall health plan rating is a high priority since CalOptima will be pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact

- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima strategic priorities and the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual patient care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2021 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2021 QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.

- Measures required by regulators, such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.

- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.

- Project coordination occurs through the various leadership structures: Board of Directors, management, QIC, UMC, etc., based upon the scope of work and impact of the effort.

- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality Measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers or predictors of the desired outcome measures or lag quality measure, such as HEDIS and Stars measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized.

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forums, and other ongoing ad hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both website and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes, and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on CalOptima's website, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation, and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED, Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)

- Supervisor, Quality Improvement, and Master Trainer (FSR)
- Supervisor, Credentialing
- QI Nurse Specialists
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:
- Quality Analytics HEDIS Manager
- Quality Analytics Pay for Value Manager
- Quality Analytics Network Adequacy Manager
- Quality Analytics Data Analytics Manager
- Quality Analytics Analysts
- Quality Analytics Project Managers
- Quality Analytics Program Coordinators
- Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:
- Population Health Management Manager (Program Design)
- Population Health Management Manager (Operations)
- Population Health Management Supervisor (Operations)
- Health Education Manager
- Health Education Supervisor
- Population Health Management Health Coaches
- Senior Health Educator
- Health Educators
- Registered Dietitians
- Data Analyst
- Program Manager

- Program Specialists
- Program Assistant

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operations)
Provides clinical operational oversight and leadership to the implementation, expansion and/or improvement of processes and services of the Behavioral Health Integration department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and UM for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management
Assists in the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective, and retrospective reviews that support UM medical management decisions, serves on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management
Leads the development and implementation of the Pharmacy Management (PM) program, develops, and implements PM department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics Committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
Responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment,

collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics
Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the road map. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the Enterprise Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization, and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.

- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.

- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.

- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.

- An evaluation of member satisfaction surveys and initiatives.

- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.

- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.

- Recommended changes included in the revised QI Program Description for the subsequent year for QIC, QAC, and the Board of Directors' review and approval.

Key Business Processes, Functions, Important Aspects Of Care And Service

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability

- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care, and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM and CM Programs and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities.
  - Drive improvement of quality of care received.
  - Minimize rework and unnecessary costs.

    - Measure the member experience of accessing and getting needed care.
    - Empower staff to be more effective.
    - Coordinate and communicate organizational information, both division and department-specific, as well as agencywide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agencywide practices that support accreditation and meet regulatory requirements.

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima and delegated to HNs and other sub-delegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and re-credentialing of OPs such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free- standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care provider (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR, and physical accessibility review survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with MMCD Policy Letter 14-004 and CalOptima policies. The Initial Medical Record Review shall be completed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that its contracted delegated HNs make certain that each member's medical record is maintained in an accurate manner that is current, detailed, organized and easily accessible to treating practitioners. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law.

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.

- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)

- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.

- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.
- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required.
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners.
- Facilitate satisfaction surveys for members.

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, Stars and HOS measures. This

information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2021 are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services, and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source, and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM programs**.** PHM programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members, and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management, Tobacco Cessation, Asthma, Immunizations, and Well Child Visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources, and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. A systemwide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner, and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of social determinates of health (SDOH). It proactively identifies those members in need of closer management, coordination, and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary

- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC, and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination, and basic are specific to SPD, OCC, and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
    - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
        - Roles and responsibilities of this team:
            - Basic case management, including advanced care planning
            - Medication reconciliation
            - Identification of member at risk of planned and unplanned transitions
            - Referral and coordination with specialists
            - Development and implementation of an ICP
            - Communication with members or their representatives, vendors, and medical group
            - Review and update the ICP at least annually, and when there is a change in the member's health status
            - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members

    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker

        - Roles and responsibilities of this team:

            - Identification and management of planned transitions
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services

- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization

- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at-high-risk individuals

- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.

- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC

In 2021, OC/OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician, or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2021 UM Program Description.

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved, and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture, and diverse needs

- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered

- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting

    - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    - Annual blood-borne pathogen and hazardous material training
    - Preventative maintenance contracts to promote keeping equipment in good working order
    - Fire, disaster, and evacuation plan, testing and annual training

- Institutional settings, including CBAS, SNF, and MSSP settings

    - Falls and other prevention programs
    - Identification and corrective action implemented to address post-operative complications
    - Sentinel events, critical incident identification, appropriate investigation, and remedial action
    - Administration of flu and pneumonia vaccines
    - COVID-19 Infection Prevention and Protective Equipment

- MRSA prevention program (Shield)

- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact, 24-hour access to telephonic interpreter services, member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- OC member materials are provided in three languages: English, Spanish and Vietnamese.
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity

- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards).
- Behavioral Health for MC, OC, and OCC lines of business
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, and peer review process on specific, referred cases
- Development of system-wide measures, thresholds, and standards
- Satisfaction surveys of members, practitioners, and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and organizational providers (OPs)
- Credentialing and re-credentialing of OPs
- Development of UM and Case Management standards
- Development of QI standards

- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2021 Delegation Grid.

See Appendix B — 2021 Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

Appendix A — 2021 QI Work Plan

APPENDIX B — 2021 DELEGATION GRID

APPENDIX C — ORGANIZATIONAL CHART

2021 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2021 QI Annual Oversight of Program and Work Plan
B. 2020 QI Program Evaluation
C. 2021 UM Program
D. 2020 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program updates (Health Network Quality Rating, MCAS, P4V)
M. Improvement Projects (All LOB)
QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC
N. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
O. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
P. Homeless Health Initiatives (HHI): Health Homes Program Phase 2
Q. Health Equity

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted to Board of Director's: Date:

Quality Improvement Committee Chairperson:

Emily Fonda, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, MD Date:

B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
C. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*, which is a NCQA Accreditation Measure

D. Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations
B. Blood Lead Screening

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Virtual Care Strategies

VIII. QUALITY OF SERVICE- Member Engagement

A. Improve Member Experience- Member Engagement

IX. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure.
   OCC Quality Withhold measure.
B. Quality of Care Grievances and Potential Quality Issue
   (GARS/PQI) Processing
C. Post-Acute Infection Prevention Quality Incentive (PIPQI)
D. Orange County COVID Nursing Home Prevention Program.

E. LTC Facility Transfer Plan due to COVID-19

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT								
2021 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2021 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by February 2021	Betsy Ha				
2020 QI Program Evaluation	Complete Evaluation 2020 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by February 2021	Betsy Ha				
2021 UM Program	Obtain Board Approval of 2021 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by February 2021	Mike Shook				
2020 UM Program Evaluation	Complete Evaluation of 2020 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by February 2021	Mike Shook				
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Pshyra Jones				
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima				
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Ana Aranda				
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook				
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD				
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital				
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V). Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital				
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures- Due March 2nd. **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo/Cathy Osborn				
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achive program milestones quarterly and annual performance goals	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Quarterly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Quarterly Adoption of Report	Edwin Poon				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Sloane Petrillo				
Homeless Health Initiatives (HHI): Health Homes Program Phase 2	Improve Health & Access to care for enrolled members	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI 5. Focus on telephonic outreach d/t COVID-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Quarterly Report	Sloane Petrillo				
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Pshyra Jones/Betsy Ha/Marie Jennis				
II. QUALITY OF CLINICAL CARE- Adult Wellness								
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	**MY2020 Goal:** **CCS -** MC 60.65% **COL** - OCC 73%, OC 62% **BCS** -MC 58.67%, OCC - 76%, OC - 76%	1) Continue $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Track the number of mammograms scheduled through targeted outreach. 4) Member Health Rewards RFP and Vendor Contract	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (16 and over).	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a.They are now eligible to be vaccinated. b.Where they need to go to be vaccinated (when available) c.This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health								
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2020 Goal:** 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:18.20 %	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	12/31/2021	Edwin Poon	Yes			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**MY2020 Goal:** MC - Init Phase - 43.41% MC -Cont Phase - 55.05%	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	12/31/2021	Edwin Poon	Yes			
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS MY2020 Goal:** **MC:NA**	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	12/31/2021	Edwin Poon	Yes			
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 41% OC 56% OCC 56%	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	12/31/2021	Edwin Poon	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE- Chronic Conditions								
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**HEDIS MY2020 Goal: (A1C Poor Control)** MC:37.47% OC: 19.46% OCC: 19.46%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Member Health Rewards RFP and Vendor Contract 3) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS MY2020 Goal: (Diabetric Eye Exams)** MC: 58% OC: 67.5% OCC: 67.5%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
V. QUALITY OF CLINICAL CARE- Maternal Child Health								
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	**HEDIS MY2020 Goal:** Prenatal 83% Postpartum 65%	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	12/31/2021	Ann Mino	Yes			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness								
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	**HEDIS MY2020 Goal:** MC 68.37%	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Blood Lead Screening	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2020 Goal**: Lead Screening 50th percentile 73.11%	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials, 4) Prop 56 provider value based payments for Blood Lead Screening	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access								
Improve Access: Reducing gaps in provider network	Contract with a minimum of 25% of targeted providers identified by the network adequacy work group.	1) Actively recruit hard to access specialties for CCN	12/31/2021	Michelle Laughlin/Jennifer Bamberg				
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists by 10 percentage points.	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After All Attempts** from 28.3% to 25.0%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Virtual Care Strategies	Increase telehealth utilization rate from 24.1% to 30% (visit count/# members) Increase member telehealth usage from 8.8% to 10% (teleheatlh member count/# members)	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	12/31/2021	Marsha Choo/Rick Cabral				
VIII. QUALITY OF SERVICE- Member Engagement								
Improve Member Experience: Member Engagement	Increase member engagement via member portal.	1) Member Portal 2) Member Outreach Calls	12/31/2021	Mauricio Flores/Andrew Tse				
IX. SAFETY OF CLINICAL CARE								
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2020 Goal**: MC - NA OC 8%;OCC 0.85 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	12/31/2021	Mike Shook	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	Provide clinical recommendations to members with a quality of care grievance within 30 days.	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	12/31/2021	Laura Guest/Ana Aranda				
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2021	Cathy Osborn/Scott Robinson	Yes			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COVID-19 as soon as possible 2) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COVID 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www.ucihealth.org/stopcovid	5/31/2021	Cathy Osborn/Scott Robinson				
LTC Facility Transfer Plan due to COVID-19	Transfer 100% of CalOptima members to other facilities within 5 days of evacuation notice.	1) Train all LTSS staff in LTC operational DTP: LTC015 LTC facilities planned and unplanned closure process. 2) Monitor all nursing facilities for COVID_19 positive rates in members and facility staff 3) Identify high-risk facilities that hae COVID-19 related staffing shortages and high infection rates that my require evacuation. 4) Identify and maintain a log of available nursing facility beds that members could be transferred to.	12/31/2021	Scott Robinson				

APPENDIX B — 2021 DELEGATION GRID

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.2.4	PHM2D: Segmentation-PHM	X		X	
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X		X	
3.4.2	NET4B: Continued Access to Practitioners	X		X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA for Interim Surveys only
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				NA for Medicaid
4.9.6	UM9F: Appeals Overturned by the IRO				NA for Medicaid
4.9.7	Provider Appeals Provider Complaint Processing	X	X	X	
4.10.1	UM10A: Written Process				NA for Medicaid
4.10.2	UM10B: Description of the evaluation Process				NA for Medicaid
4.11.1	UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X	
4.11.2	UM11B: Pharmaceutical Restrictions/Preferences	X		X	
4.11.3	UM11C: Pharmaceutical Patient Safety Issues	X		X	
4.11.4	UM11D: Reviewing and Updating Procedures	X		X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.11.5	UM11E: Considering Exceptions	X		X	
4.12.1	UM12A: UM Denial System Controls	X	X	X	
4.12.2	UM12B: UM Appeal System Controls	X		X	
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				NA due to Carve out
5.7.4	CR7D: Assessing Medical Providers	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.5	CR7E: Assessing Medical Providers				NA due to Carve out
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations				NA for Medicaid
6.3.2	ME3B: Communication with Prospective Members				NA for Medicaid
6.3.3	ME3C: Assessing Member Understanding				NA for Medicaid
6.4.1	ME4A: Functionality: Website	X		X	Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X		X	Not Required for Renewal Survey

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			May not be Delegated
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Claims Processing Timeliness of Claims and Interest on Late Claims	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR)	X	X	X	

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2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
7.1.7	Third Party Liability (TPL) CalOptima policy FF.2007: Reporting of Potential Third-Party Liability.	X	X	X	
7.1.8	Family Planning Services CalOptima Policy GG.1118: Family Planning Services, Out-of-Network	X	X	X	

Note: NCQA Elements are based on current 2020 HP Standards.

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APPENDIX C — ORGANIZATIONAL CHART

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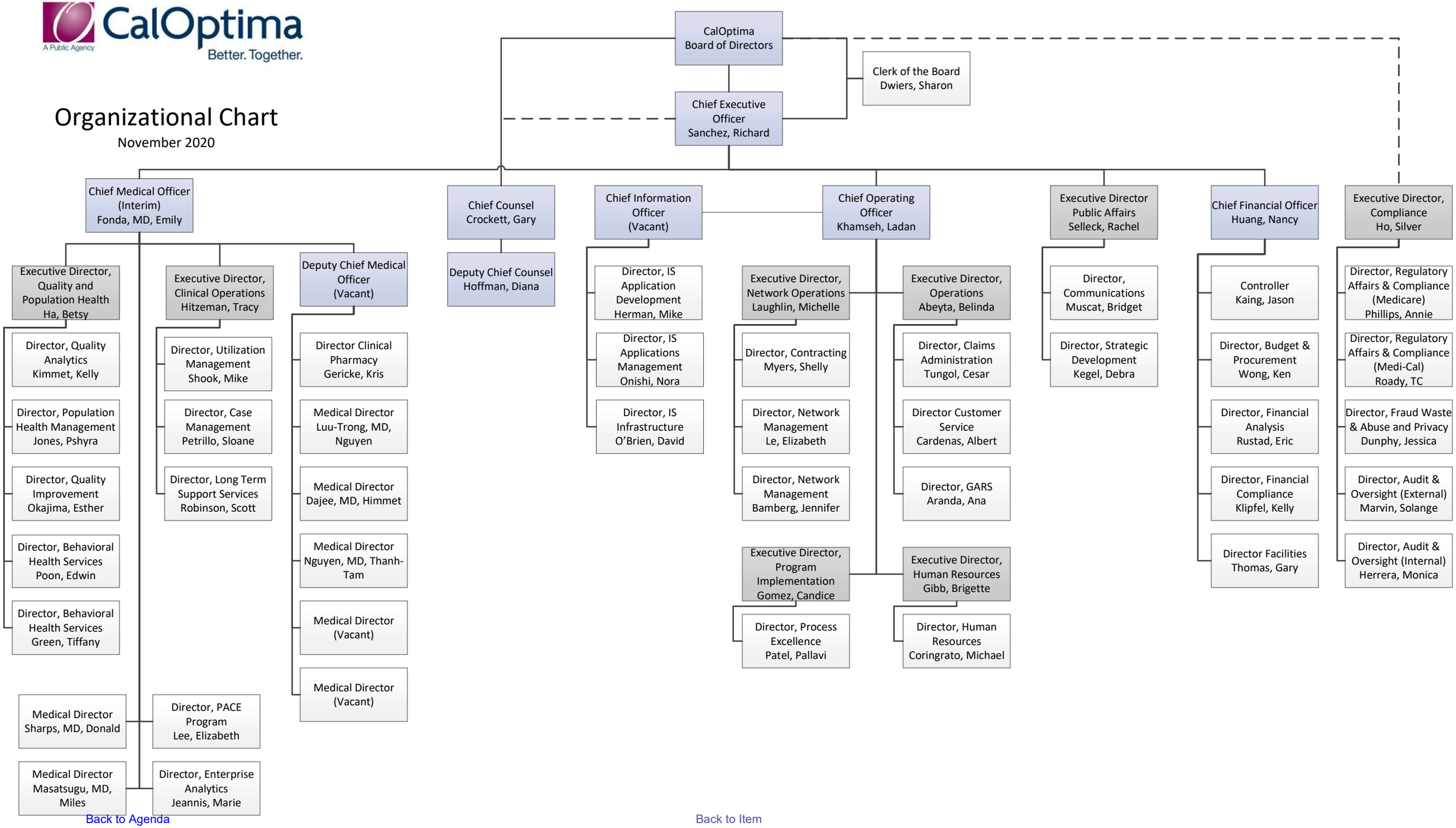
Organizational Chart

November 2020



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2021 Quality Improvement Program and Work Plan

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021

Esther Okajima
Director, Quality Improvement

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2020 QI Accomplishments

- Recognized by DHCS as the highest performing Medicaid plan in California.
- Met all DHCS Managed Care Accountability Set (MCAS) measures required to achieve Minimum Performance Level (MPL) in measurement year (MY) 2019.
- Performed successful incentive outreach to members in MY 2019 to obtain preventive care, which demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, breast and cervical cancer screening
- Demonstrated the highest ACE screening rate among MCPs (6.3% vs State Average of 3 %)

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2020 QI Accomplishments (con't)

- Recognized and rewarded outstanding performance of Health Networks and CalOptima Community Network through comprehensive Pay for Value (P4V) performance measurement program.
- Extended CalOptima's Homeless Health Initiative which included Clinical Field Team (CFT) and Community Health Center (CHC) efforts.
- Implemented Post-acute Infection Prevention Quality Initiative (PIPQI), as well as participated in the Orange County Nursing Home Infection Program to reduce spread of COVID-19
- Responded to COVID-19 pandemic and amplification of health disparities for persons of color

2020 QI Evaluation Recommendations

- Develop comprehensive COVID-19 strategy to mitigate impact and expand virtual care strategies to increase access for members
- Continue member “health rewards” incentive program, specifically for preventive screenings
- Expand member incentive to promote COVID-19 vaccine acceptance
- Intensify targeted member outreach by utilizing multiple modes of communications
- Prioritize data bridge efforts to improve data exchanges to boost measures now considered administrative

2021 QI Program Description

- QI Program Changes and Updates
- QI Program Goals:
  - Aim for 70% COVID19 vaccine rate as a stretch goal to ensure member safety during COVID19 pandemic.
  - Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.
  - Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0

2021 QI Program Work Plan (Appendix A)

- COVID-19 Related Initiatives
- Added and Retired Initiatives
  - Program Oversight
  - Quality of Clinical Care
  - Safety of Clinical Care
  - Quality of Service

2021 QI Program Delegation Grid (Appendix B)

- CalOptima Responsibilities
- Activities Delegated to Health Networks
- Activities Delegated to Kaiser

Questions

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Our 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 March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887

Recommended Action

Receive and file the 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation

Background

The Board of Directors first authorized submission of CalOptima's application to become a Program of All-Inclusive Care for the Elderly (PACE) Provider on October 7, 2010. The CalOptima PACE program opened in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents. As of December 31, 2020, CalOptima PACE had 395 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions made to the following year's QI Plan. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.

Discussion

The COVID-19 pandemic in 2020 was a year of unprecedented challenges which significantly impacted CalOptima PACE. CalOptima PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus. In mid-March 2020 when the pandemic was declared, the scope of delivery of health care services had to instantly adjust to numerous health orders and recommendations from the national, state and county levels. Our first response at that time was to close the PACE day center to limit the congregation of our high-risk population. Understanding the profound importance of maintaining contact with PACE participants, we implemented daily "wellness calls" to check in on

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the well-being of our participants. Since the onset of the pandemic, over 20,000 wellness calls kept participants connected with PACE. The PACE clinic continued operations and a new triage system was developed to accommodate requests from our participants for urgent and same day visits with our medical providers. Understanding the importance of continuing to provide preventive health services, we implemented drive-through immunization hours which eventually also led to drive-through COVID-19 testing. At the end of April, PACE along with others in the health care community, received a waiver from the Centers for Medicare & Medicaid Services (CMS), to provide the flexibilities needed to take care of patients during the public health emergency. This improved our ability to provide services beyond the existing walls of the PACE Center and assume a more home-based model, called "PACE without Walls." We developed a service delivery matrix to continue providing existing PACE care services including medical management, nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services, and personal care services. As with other providers in the community, the pandemic also led to a rapid increase in the utilization of telehealth as PACE developed and implemented a HIPPA compliant telehealth solution this year.

These changes and the pandemic itself affected several our quality goals. Although we ended the year with 93% of our participants vaccinated against influenza, we did not meet our goal of 94%. This was in part due to participants who were fearful of having any contact with staff. They did not want to come to the drive-thru immunization clinics and did not want anyone going to their home. The pandemic also impacted our enrollments and disenrollments. Beginning in March, we saw a decrease in enrollments and an increase in disenrollments, which has led to flat growth for the remainder of the calendar year. The disenrollments were impacted by participants who moved to be near family during the pandemic. We also did not meet our advanced care planning goal, as only 94% of our participants had a Physicians Orders for Life-Sustaining Treatments (POLST) completed verses the goal of 95% which was in part because we did not see participants in person as frequently as before the pandemic due to the PACE day center closure. This limited the opportunities to review and discuss the POLST. COVID-19 significantly impact our inpatient bed days as most of the hospital admissions during the fall and winter months were due to COVID-19. Finally, although we continued to meet all our participant satisfaction goals, we did see our score fall in 7 of the 10 participant satisfaction domains as well as our overall weighted score. This was a direct result of staff having significantly decreased face-to-face interactions with participants due to the closure of the PACE day center.

Regardless, the PACE program still met 21 of the 26 work plan goals. By swiftly responding to the pandemic, implementing "PACE without Walls" and redesigning our clinical workflows, we were able to continue to deliver high quality care as evidenced our continued low respiratory infection rates despite the pandemic, 100% functional status assessment completion rate, 99% medication reconciliation post-discharge rate, our low potentially harmful drug/disease interactions in the elderly rates and high diabetes care quality rates. PACE lowered our ER visit rate, kept our 30 day all cause readmission rate at 10% and had only 1.7% of our participants in long term care verses the California PACE average of 3%. Next year, we will add specific measure focused on COVID-19 and a quality initiative focused on telehealth to build on the successes we had in telemedicine this year.

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Fiscal Impact
None

Rationale for Recommendation
PACE organizations are required to establish a QI program. Through the Code of Federal Regulations (CFR), 42 CFR section 460.130 (a), the Centers for Medicare & Medicaid Services (CMS) requires a PACE organization must develop, implement, maintain, and evaluate an effective, data-driven quality improvement program. As per 42 CFR section 460.132(a) and (b), the PACE organization leadership presents their QI Plan and any revisions to their governing body for annual approval to ensure effective organizational oversight. CMS and the state will review the plan during subsequent monitoring visits.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee (Anticipated February 25, 2021) Approved 2/25/2021

Attachments
1. Proposed 2020 CalOptima PACE Quality Improvement (QI) Plan Evaluation
2. Appendix B – 2020 CalOptima PACE QI Work Plan

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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CalOptima Program of All-Inclusive Care for the Elderly

2020

Quality Improvement Plan

Annual Evaluation

PACE CalOptima
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SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

_____ _____

Miles Masatsugu, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Mary Giammona, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Andrew Do **Date**
Supervisor, First District

TABLE OF CONTENTS

2020 CalOptima PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

The COVID-19 pandemic in 2020 was a year of unprecedented challenges impacting all areas of everyone's lives. CalOptima PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus.

In mid-March, 2020, when the pandemic was declared, the scope of delivery of health care services had to instantly adjust to numerous health orders and recommendations from the national, state and county levels. Our first response at that time was to close the PACE Center apart from our in-house clinic services. All guests, employees and participants were screened upon entry into the PACE Center and over 70% of our staff were re-assigned to temporary telework.

Understanding the profound importance of maintaining contact with PACE participants, we implemented daily "wellness calls" to check in on the well-being of our participants. Since the onset of the pandemic, over 20,000 wellness calls kept participants connected with PACE.

The PACE Clinic continued operations and a new triage system was developed to accommodate requests from our participants for urgent and same day visits with our medical providers. Understanding the importance of continuing to provide preventive health services, we implemented drive-through immunization hours which eventually also led to drive-through COVID-19 testing.

At the end of April, PACE along with others in the health care community, received a waiver from the Centers for Medicare & Medicaid Services (CMS), to provide the flexibilities needed to take care of patients during the public health emergency. This improved our ability to provide services beyond the existing walls of the PACE Center and assume a more home-based model, called "PACE without Walls." We developed a service delivery matrix to continue providing existing PACE care services, including medical management, nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services and personal care services. Training and education were provided to staff who delivered care services at participants homes. Those services started in June. Additional "PACE without Walls" services delivered by our transportation team, included monthly care packages containing items such as activity books, calendars, and socks. Participants eagerly awaited these care packages and the opportunity to connect with others beyond their home.

When we recognized that the pandemic will inevitability change the landscape of health care delivery for the long-term, we pursued telehealth platforms. In early November, we implemented our newly contracted telehealth system and diligently worked with PACE participants to determine access to mobile devices, their level of comfort with using the devices, broadband capabilities in their homes, and whether they needed assistance to install the telehealth application. The telehealth service delivery has expanded our access with participants, not just during the pandemic, but also post-pandemic. It should be noted, however that face-to-face encounters are always preferred, and will always be utilized for initial participant assessments or when telehealth is not an option.

Despite the COVID-19 pandemic being declared in mid-March, we continued to enroll new participants through a virtual modality. Naturally, our enrollment goals were not met, although we have seen an increase over the latter part of fourth quarter. When CalOptima PACE opened for operations on October 1, 2013, we had 13 participants. We have seen steady growth in enrollment. At the end of 2020, we had 394 participants. The multi-cultural background and the diversity of our participant population provides a very vibrant and engaging environment. Currently, 10 languages are spoken by our participants, with 82% of the participants speaking English as their second language. Out of our 394 participants, the preferred languages are 58% Spanish, 18% English and 16% Vietnamese. Other languages spoken include Korean, Tagalog, Chinese, Hindu, Urdu, and Telugu.

The purpose of the CalOptima PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes, and reduce the potential risk to safety and health of PACE participants through ongoing risk management. This is done via data-driven assessments of the program, which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

The goals of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff. The 2020 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2021 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima PACE QI Plan is developed annually by the PACE QI Committee (PQIC). It is then reviewed and approved by the CalOptima Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors. The 2020 PACE QI Plan was reviewed and approved by the CalOptima Board of Directors on April 20, 2020.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI manager will ensure timely collection and completeness of data with the support of the PACE QI program specialists. Overall, oversight of PACE QI is provided by the CalOptima Board of Directors.

The CalOptima PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima's PACE participants.

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2020, CalOptima PACE accomplishments include:

1. Responded quickly to the COVID-19 pandemic, to follow federal, state, and local guidance.
2. Implemented a clinic triage system to continue to provide health care access to participants during the pandemic.
3. Implemented a telehealth platform that enabled participants to "visit" their providers from their homes.
4. Implemented PACE without Walls which provided skilled and non-skilled services to participants outside of the PACE Center during government mandated stay-at-home orders.
5. Connected with participants through more than 20,000 wellness calls, and more than 32,000 home delivered meals and care packages.
6. Provided aggressive infection control training to staff.
7. Deployed more than 70% of staff to work remotely from their homes.
8. Provided weekly COVID-19 updates to the leadership team and monthly updates during our all-staff meetings.
9. Completed two Quality Initiatives: Advance Health Care Directive and Immunizations.
10. Met 21 out of 26 Work Plan goals.
11. 93% of participants received their annual influenza vaccine.
12. 98% of participants received the Pneumococcal vaccine.
13. Achieved respiratory infection rates in the elderly 35% lower than national benchmarks.
14. Implemented enhanced care coordination program for participants with dialysis.
15. 99% of participants had their medications reconciled within 30 days of hospital discharge.
16. Provided prompt review by clinical pharmacist of specialty medications ordered by outside specialists.
17. Performed retrospective reviews of medication utilization daily and monthly. Recommendations were immediately addressed with the PACE provider and/or IDT.
18. Only 0.64 falls per 1000 members month occurred at the PACE Center in 2020.
19. Quality of Diabetes Care
    a. 98% of participants with diabetes completed an annual eye exam.
    b. 100% of participants with diabetes had nephropathy monitoring.
    c. 87% of participants with diabetes had their blood pressure controlled.
20. Utilization:
    a. Only 1.7% participants were placed in long-term care in 2020.
    b. Refined the PACE Emergency Room (ER) Diversion program.
    c. Continued to provide in-house specialists including podiatry, dental, and optometry for improved access and coordination of care.
    d. Morning clinical huddles were incorporated into the IDT meetings for all teams.
21. Transportation:
    a. More than 35,000 trips with an on-time performance of 98%.

22. Participant Satisfaction
    a. 89% overall satisfaction with care received compared to the national average of 88.3%.
    b. 93% said the services they received at PACE improved or maintained their quality of life.
    c. 91% said they would recommend the program to a close friend.
    d. 6 of the 10 participant satisfaction domains scored higher than the national average.
23. 100% of staff competency assessments were completed. Year-round staff trainings covering a broad area of topics included coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests and rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings was high, especially as it pertains to the unique needs of the population. This was accomplished and evidenced by:
    a. The ongoing HPMS and QI individual metric data collection and analysis.
    b. The ongoing PACE QI initiatives.
    c. The monitoring of member grievances and complaints, and regular review of delegated entities.
    d. The monthly meeting with the transportation vendor.
    e. The daily morning inpatient and nursing facility clinical reviews.
    f. By the ongoing infection control activities.
    g. Collaboration with the Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality breaches, security, etc.
    h. The annual approval of up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
    i. The Redesigned PACE Clinic Workflow/Triage to efficiently address participant care issues during the 2020 COVID-19 pandemic.
    j. Implemented a telehealth platform that enabled enhanced access to care during the pandemic.
    k. Developed a relative value unit (RVU) measurement to monitor the productivity of staff, including those deployed as teleworkers.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners, was accomplished and evidenced by:
    a. The daily Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Addition of hospital and nursing home attending physicians to the IDT.

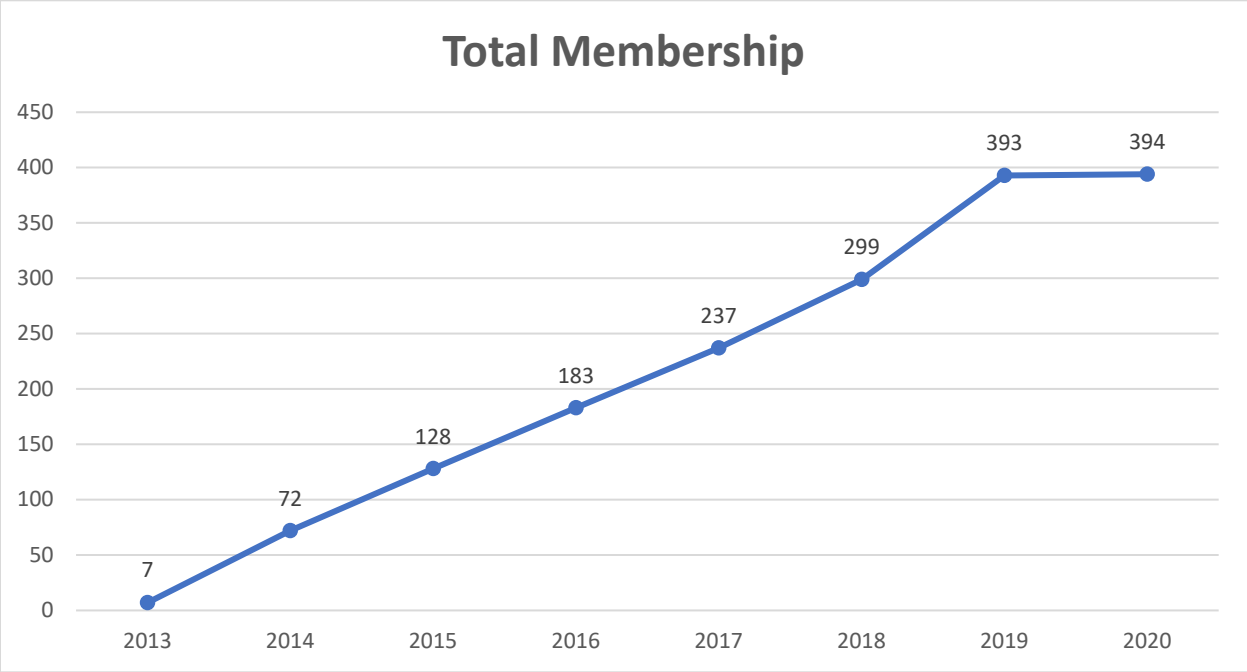
    c. Addition of preferred specialists that agreed to participate in IDT.
    d. The coordination of care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population was accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. A nurse practitioner that specializes in podiatric procedures, an optometrist, and a dentist at the PACE clinic to see and treat the PACE participants.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service was accomplished and evidenced by:
    a. The credentialing and peer review process.
    b. Annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances was accomplished and evidenced by:
    a. The improvements in the PACE Participant Satisfaction Survey.
    b. The summary of grievance and appeals activities.
    c. The ongoing PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes were accomplished and evidenced by:
    a. The QI activities which occur around all Unusual Incidents.
    b. Physical therapy driven groups such as Fall Prevention Group, Fall Committee, Fallers Anonymous and Matter of Balance groups.
    c. Root cause analysis done on Unusual Quality Incidences.
8. Compliance with regulatory agencies and accreditation standards was accomplished and evidenced by:
    a. The successful submission of data as required by CMS and DHCS.
9. Compliance with clinical practice guidelines and evidence-based medicine was accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The adoption of Uptodate.com clinical practice standards.
    c. On-going staff training.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently was accomplished and evidenced by:
    a. Tracking, trending, and analyzing utilization management (UM) data monthly.
    b. The provider incentive program.
    c. The coordination of care found in the ER Diversion Program.
    d. The weekly PACE management team meetings.
    e. Full implementation of the PACE 2.1 initiative, promoting program growth and employee engagement.
    f. Continued expansion of *PACE without Walls* program.
    g. The participation in the CalOptima QI, UM, and Credentialing and Peer Review Committee meetings.
    h. The participation in the CalOptima Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

i. Two quality initiatives which focused on participant immunizations and advance health care directives.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima PACE offers a community-based program that provides all necessary medical care, coordination, and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission eight years later. At the end of 2013, we had seven participants enrolled and now, seven years later, we have 394 participants.



As illustrated in the first membership graph, PACE has seen a steady enrollment trend over the years. In 2018, it was a particularly notable year for enrollment, as this was the year we implemented "PACE 2.0" a collaborative PACE-team effort focused on program growth and expansion. The tenets of PACE 2.0 were to create a context for change by developing a process for optimizing enrollment and establishing organizational capacity to promote continued growth.

One of the ways in which capacity for growth was championed was through partnerships with area Community-Based Adult Service (CBAS) centers. These partnerships became alternative care sites (ACS) for participants, and through the addition of these sites we were able to increase our enrollment capacity. Pre-pandemic, over 60 PACE participants received PACE services through these alternative care sites. Despite the substantial challenges that PACE faced with the COVID-19 pandemic in 2020, we continued to enroll participants into our program and persist in providing essential health services to our communities. In 2021, our goals for program growth remain intact and strategies are already being put into place to accommodate participants post-pandemic. We expect to return to our 2019 growth rates once the pandemic subsides and we can again go out into the community to market the program.

2020 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI20.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 19, 2020.

QI20.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 19, 2020.

QI20.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2020.

Goal: Not Met

Data/Analysis: 93% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

With a year-end vaccination rate of 93%, we fell short in meeting our goal by one percentage point. This was despite an aggressive flu vaccination campaign with weekly drive through vaccine clinics. All participants who have not been vaccinated have had discussions with our providers and have refused. Vaccines were ordered in late spring from our distributor and we began to vaccinate participants when vaccines arrived in mid-August. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the PCP and RN's who personally reached out to the unvaccinated participants. It is important to note that enrollees in the month of December, were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

PACE staff also received their flu vaccine through employee health services, expanding the scope and engagement of the flu vaccine campaign. It is important to note that CalOptima PACE reported zero influenza outbreaks among our participants or staff in 2020.

Due to the COVID-19 pandemic, many participants were reluctant to step out of their homes and into the community, which could potentially expose them to the COVID-19 virus.

Our 2020/2021 vaccination efforts will continue through quarter 1 of 2021 where we will continue to reach out to the unvaccinated.

QI20.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their pneumococcal vaccination by December 31, 2020.

Goal: Met

Data/Analysis: 98% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2020, 98% of our participants had received the pneumococcal vaccine, exceeding our goal. This was an improvement from the 95% who met this metric in 2019. Much of our success is attributed to the implementation of the following protocols:

a. Designated Immunizations as a Quality Initiative with quarterly dashboard presentations during PACE Quality Improvement Committee meetings.

b. Established standing orders and standardized procedures in vaccine administration. This eliminated the need to wait for a physician order by delegating this responsibility to a registered nurse who has demonstrated the required competency.

c. Utilize the electronic medical record's (EMR) quality analytics, and other data platforms to track missed opportunities for immunization.

d. Implemented drive-through vaccination clinics throughout the year.

e. Undertook outreach by PACE PCP's to those participants who refused the vaccine.

The PACE QI department provided detailed monthly reports which specified which participants still needed the vaccination. It was then shared with all participant's medical providers. As with previous years, one of our challenges was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines.

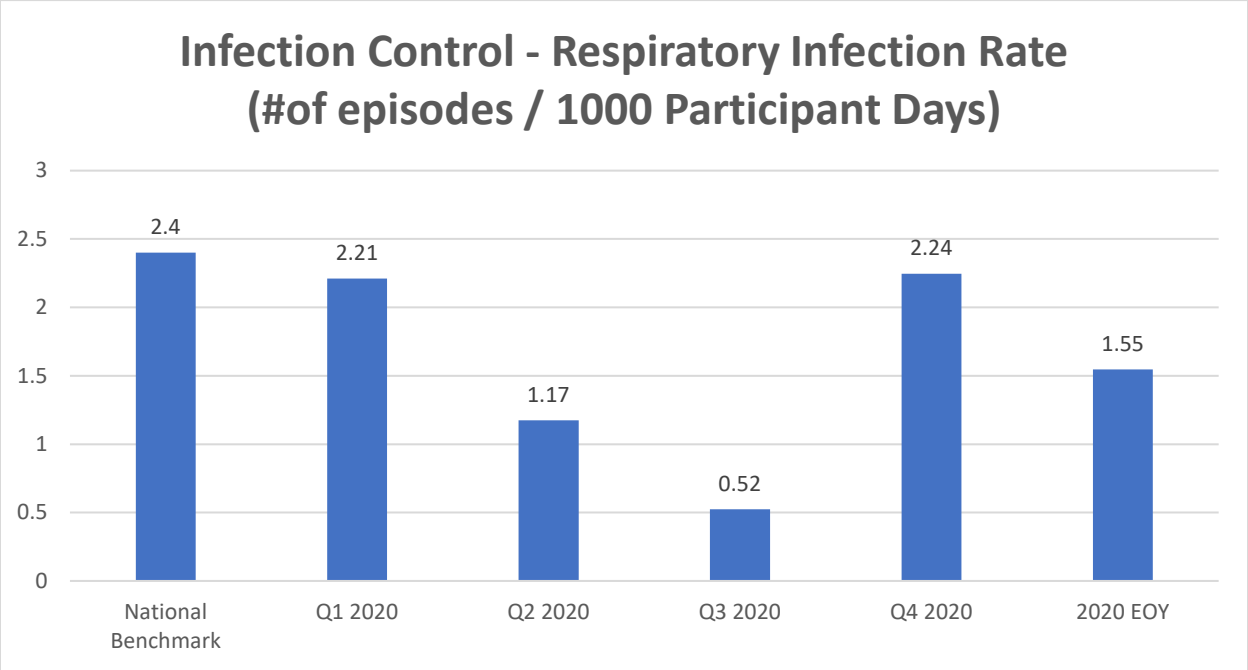
In 2021, we plan to continue with existing strategies to meet our goals for the pneumococcal vaccine. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

QI20.05 Reduce common infectious in PACE participants (Respiratory Infection)

Goal: Maintain common respiratory infection rate less than the following national benchmarks: Respiratory Tract 0.1–2.4 episodes/1000 participant days.

Goal: Met

Data/Analysis: The 2020 rate was 1.55 episodes per 1000 participant days.



Summary and Key Findings/Opportunities for Improvement:

Despite the COVID-19 pandemic, we were able to conclude the year below the national benchmark. As in previous years, we focused heavily on infection control in 2020 with increased surveillance due to the emergence of COVID-19. At the onset of the pandemic, we ceased day center on-site activities for participants and reassigned eligible staff to telework status. We screened all individuals accessing the PACE Center and enacted a mask mandate for all individuals at the center. We ordered and tracked our personal protective equipment (PPE) inventory and enhanced environmental controls such as surface disinfection. We provided a comprehensive infection control training which covered blood borne pathogens, droplet vs. aerosol COVID-19 transmission, handwashing, and proper use of PPE. In June, following the guidance of Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency, we conducted drive thru COVID-19 testing for our participants who were symptomatic. All positive COVID-19 participants received daily phone calls from their PCP and ancillary health staff. Over the course of months, we expanded COVID-19 testing to participants with known positive contacts and implemented contact tracing for those participants who had acquired the virus through community transmission. When we realized that the upcoming influenza season may coincide with the COVID-19 pandemic, we began our influenza vaccination program as soon as

the vaccine was released. This assured a high number of vaccinated individuals early in the flu season thereby reducing potential influenza outbreaks among our participants which could exacerbate the COVID-19 pandemic. We also included an aggressive campaign to vaccinate participants with the two pneumococcal vaccines, PCV13 and PPSV23. Other actions taken to minimize the risk of respiratory infections were interventions such as providing home nebulizer machines to participants with COPD, CHF and asthma.

Keeping abreast of the trending of the COVID-19 virus and anticipating surges allowed us to plan for the "worst case scenarios" and implement a solid infection control plan.

QI20.06 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2020.

Goal: Not Met

Data/Analysis: 94% of participants enrolled in the PACE program for 6 months had POLST by the end of 2020.

Quarter 2020	Completion Rate
Q1	99%
Q2	95%
Q3	94%
Q4	90%
EOY	**94%**

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal. With stay-at-home orders in place for most of the year, the one-on-one encounter necessary for a POLST completion was not feasible. However, end-of-life care which is consistent with the participants wishes are still reviewed with the participant and the PCP during telehealth encounters. End-of-life and palliative care discussions continue to be integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's care plan.

QI20.07 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100% of participants have functional status assessment completed every 6 months by the disciplines required by CMS.

Goal: Met

Data/Analysis: 100%

Functional Status Assessment	Q1 2020	Q2 2020	Q3 2020	Q4 2020	EOY
Charts with All Assessments	399	391	377	393	1560
Census at End of Quarter	399	391	377	393	1560
Rate	**100%**	**100%**	**100%**	**100%**	**100%**

Care for Older Adults: Functional Status Assessment				
	2020 Star Rating Measure Cut Points			
MY 2020 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	55% to 71%	71% to 85%	85% to 93%	**≥ 93%**

Summary and Key Findings/Opportunities for Improvement:

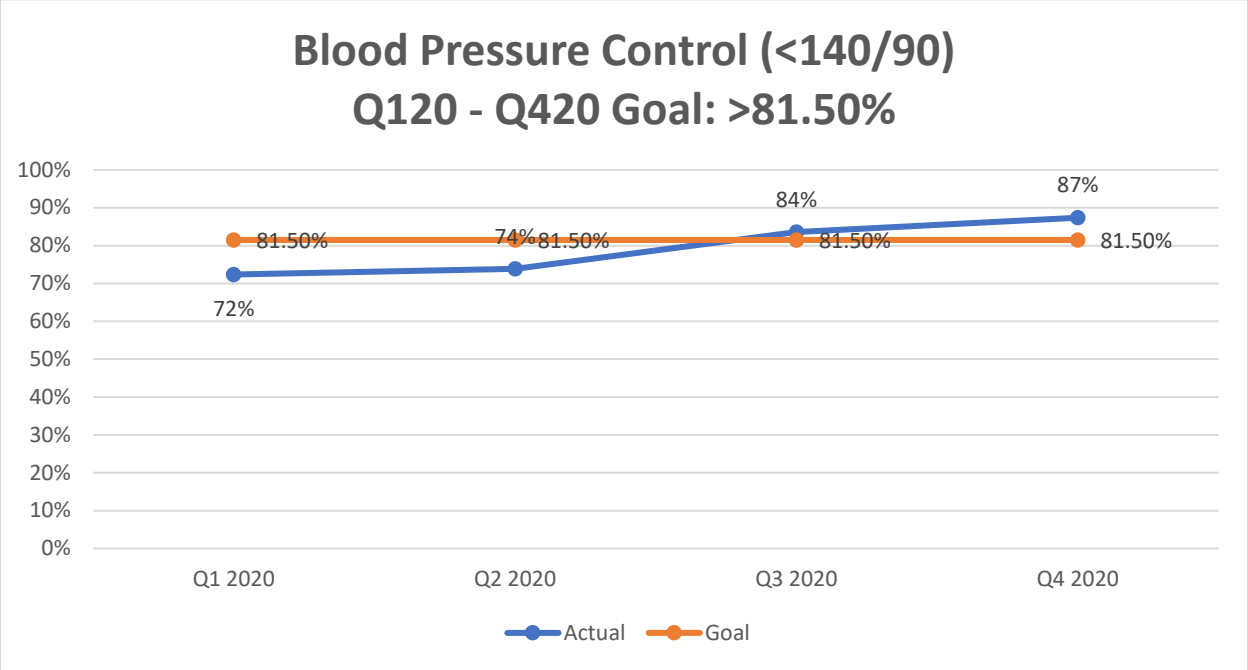
Annual and semi-annual functional assessments are critical components in determining a participant's medical, psychosocial, and cognitive status. These assessments assist in identifying risk factors and interventions necessary for optimal outcomes. A key factor in achieving this has been the monthly reports generated by the QI department specifying which participants required the functional assessment. This prompts the IDT disciplines to schedule the appointment, communicate with the family/caregiver regarding the appointment and coordinate transportation for the participant. Our success in this element places us comparable to a 5-Star Medicare rating based on the 2020 Star Rating Measure Cut Points.

QI20.08 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 81.50% of Diabetics will have a Blood Pressure of <140/90

Goal: Met

Data/Analysis: The 2020 final rate was 87%.



Diabetics with Controlled Blood Pressure					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
87%	64.72%	69.53%	76.56%	81.50%	**84.91%**

Diabetes Care: Blood Sugar Controlled				
	2020 Star Rating Measure Cut Points			
MY 2020 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
87%	37% to 61%	61% to 72%	72% to 85%	**≥ 85%**

Summary and Key Findings/Opportunities for Improvement:

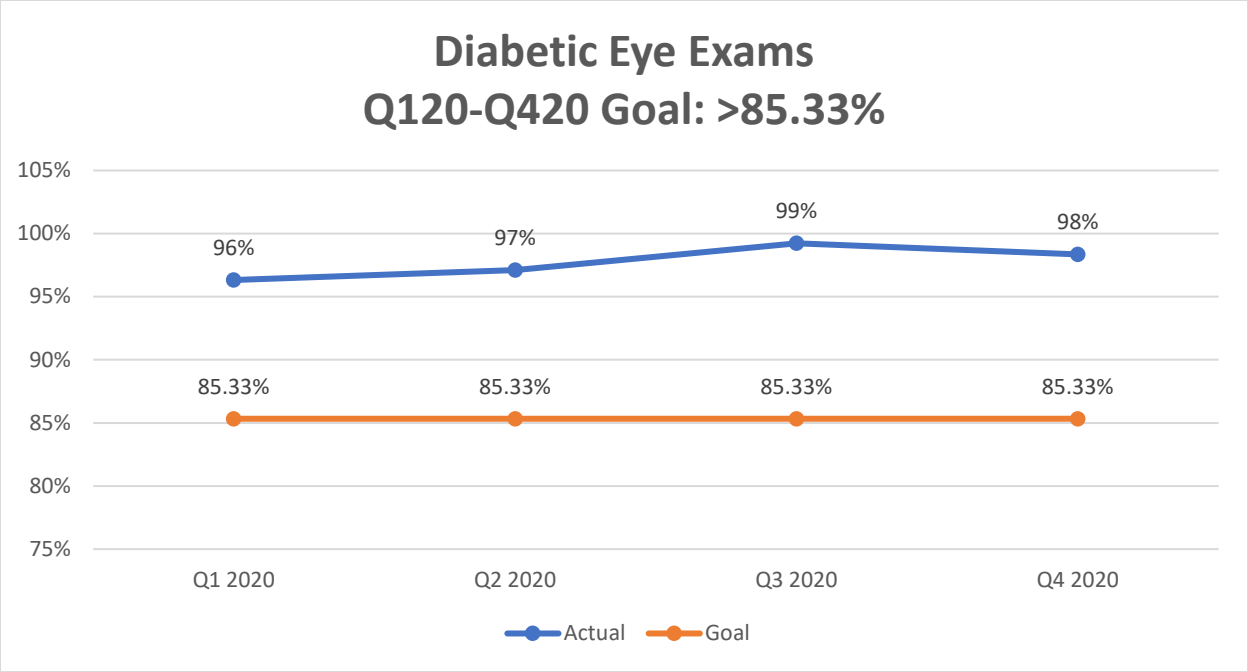
We exceeded our goals in this element and increased our performance by 3 percentage points from 2019. Prompt identification of participants with poor control of their blood pressure and monthly generated reports contributed to the success in this element. Those participants with out-of-range numbers are monitored leading to direct interventions such as medication adjustments. Our in-house pharmacist also provided recommendations for those participants who have difficulty maintaining adequate blood pressure control. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile and a 5-star Medicare rating based on 2020 Star Cut Points.

QI20.09 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 85.33% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2020 final rate was 98%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
98%	67.75%	75.28%	82.00%	85.33%	**87.10%**

Diabetes Care: Eye Exam					
	2020 Star Cut Points				
MY 2020 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
98%	<63%	63% to 69%	69% to 73%	73% to 78%	>/= **78%**

Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 98% of diabetic participants that received an annual eye exam in 2020. With the assistance of monthly reports generated by the PACE QI team, medical providers were alerted to those participants who required eye exams. Those participants were then scheduled for an appointment with their PCP on an annual and semi-annual basis. Our 2019

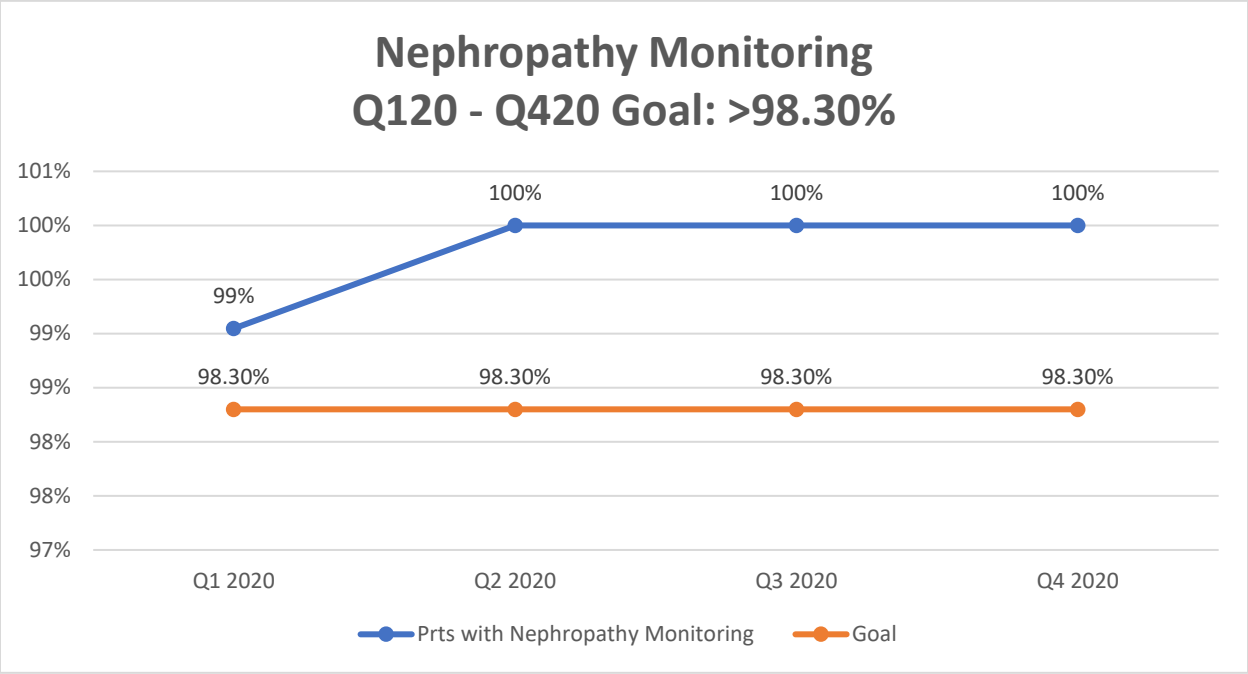
purchase of optometry equipment allowed us to provide immediate access to our participants for diabetic eye exams with a contracted optometrist. In addition, contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95% percentile.

QI20.10 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.30% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2020 final rate was 100%.



Comprehensive Diabetes Care: Medical Attention for Nephropathy					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
100%	94.19%	95.95%	97.08%	98.30%	**98.78%**

Comprehensive Diabetes Care: Nephropathy Monitoring				
	2020 Star Rating Measure Cut Points			
MY 2020 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	NA	80% to 95%	95% to 97%	**≥ 97%**

Summary Key Findings/Opportunities for Improvement: In 2020, 100% of our diabetic participants received nephropathy monitoring, exceeding our success from 2019. The PACE QI department works closely with the medical team in providing data generated reports identifying which participants required nephropathy screening/monitoring. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile.

QI20.11 Decrease the rate of participant falls occurring at the PACE day centers

Goal: <6.65 Falls per 1000 member months occurring at the PACE day centers (ACS and Garden Grove PACE)

Goal: Met

Data/Analysis: The 2020 rate was 0.64 falls per 1000 member months.

Quarter 2020	# Falls	Member Months	# Falls Per 1000 Members Months
Q1	3	1191	2.52
Q2	0	1192	0.00
Q3	0	1143	0.00
Q4	0	1173	0.00
EOY	**3**	**4699**	**0.64**

Summary Key Findings/Opportunities for Improvement:

We met our goal for day center falls during 2020. However, it should be noted that few participants were in the PACE Center due to the COVID-19 pandemic starting in late quarter 1. Beginning in quarter 3 of 2020, we began to track and monitor participants who fell at home and within the community. We examined various elements of each fall, such as where they occurred and the contributing factors. In 2021, we intend to change the quality element of "Falls in the Day Center" to "Falls at Home or in the Community" as this will more accurately reflect our efforts in ensuring participant safety. Several interventions have been discussed such as assessing the participant's home/community environment for barriers to safe movement/mobility. At the recommendation of our medical team, we initiated the *Fall Risk Assessment Tool* (FRAT) during Interdisciplinary Team meetings. This tool analyzed a participant's previous falls and examined predictors for future falls. Medications which may increase fall risk and cognition status are also reviewed. The FRAT is very similar to the root cause analysis which the QI Team facilitates for each injury resulting fall.

QI20.12 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <35.73%

Goal: Met

Data/Analysis: The 2020 rate was 30%.

DDE: Dementia + Tricyclic Antidepressant or Anticholinergic Agents					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
30%	44.44 %	40%	35.73%	33.96%	**33.96%**

Summary and Key Findings/Opportunities for Improvement:

In 2020, 30% of our participants who were diagnosed with dementia, were prescribed a tricyclic antidepressant or anticholinergic agent. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed the cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered "red flags" per CMS and Beer's criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile.

QI20.13 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Non-aspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.90%

Goal: Met

Data/Analysis: The 2020 rate was 2.7%.

DDE: CKD+ Non-aspirin NSAIDS or Cox2 Selective NSAIDs				
	2019 Medicare Quality Compass			
MY 2020 PACE	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
2.7%	9.31%	6.36%	3.90%	**2.47%**

Summary and Key Findings/Opportunities for Improvement:

Careful review of participants with chronic kidney disease who are prescribed NSAIDS is an important factor in limiting the progression of kidney disease. Our in-house clinical pharmacist is a vital asset in monitoring potential drug/disease interactions and presenting therapeutic alternatives to the medical provider. The continued coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results are comparable to the 2019 Medicare HEDIS Quality Compass 90th percentile.

QI20.14 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 120mg

Goal: 100% of participants receiving opioids for 15 or more days at an average MME 120mg will be reevaluated monthly by their treating provider.

Goal: Not Met

Data/Analysis: The 2020 rate was 57% (4 out of 7 participants were reevaluated monthly)

Quarter 2020	# Participants with High Dosage of Opioids
Q1	1 out of 2 participants reevaluated (50%)
Q2	0 out of 2 participants reevaluated (0%)
Q3	1 out of 1 participant reevaluated (100%)
Q4	2 out of 2 participants reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

In the first and second quarters of 2020, we had challenges in meeting our goal; however, an aggressive and pro-active effort was implemented in response. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing.

During the latter part of quarter 2, a template was developed and then integrated into our EMR. This template prompts the medical provider to address key points in prescribing opioids and engage the participant in a discussion around narcotic use. The PACE QI department generates a monthly report of participants who are prescribed higher opioid doses and this list is shared with the medical team. These specific participants are then automatically added onto the provider's monthly schedule so that appropriate participant/PCP follow-up can occur. Discussions around prescribing opioids is a recurring agenda item on weekly provider meetings, thereby enhancing provider education. We will continue to track and monitor this in 2021 and anticipate that with the newly implemented template, we will achieve 100% in 2021.

QI20.15 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2020

Goal: Met

Data/Analysis: 99% of participants had medications reconciled within 30 days post discharge in 2020.

Medication Reconciliation Post-Discharge	Q1 2020	Q2 2020	Q3 2020	Q4 2020	EOY
Total # of Discharges	45	28	37	35	**145**
Received Reconciliation	44	28	37	35	**144**
Rate	**98%**	**100%**	**100%**	**100%**	**99%**
Goal	**90%**	**90%**	**90%**	**90%**	**90%**

Medication Reconciliation Post-Discharge				
	2019 Medicare Quality Compass			
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	**90th Percentile**
99%	36.83%	46.16%	59.74%	**71.43%**

Medication Reconciliation Post-Discharge					
	2020 Star Rating Measure Cut Points				
MY 2020 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
99%	<48%	48% to 62%	62% to 71%	71% to 84%	**≥ 84%**

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center and provides us with our hospitalists and nursing home physicians. In 2019, the contract with House Calls Medical Associates extended to the provision of PCPs within the PACE clinic. Through this partnership, our providers maintain a close relationship with our participants and can take care of our participants across all levels of care thereby improving continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge. Our clinical pharmacist also plays a vital part in the reconciliation process as well as a dedicated additional clinical staff member who handles medication reconciliation for hospital and SNF discharges. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile.

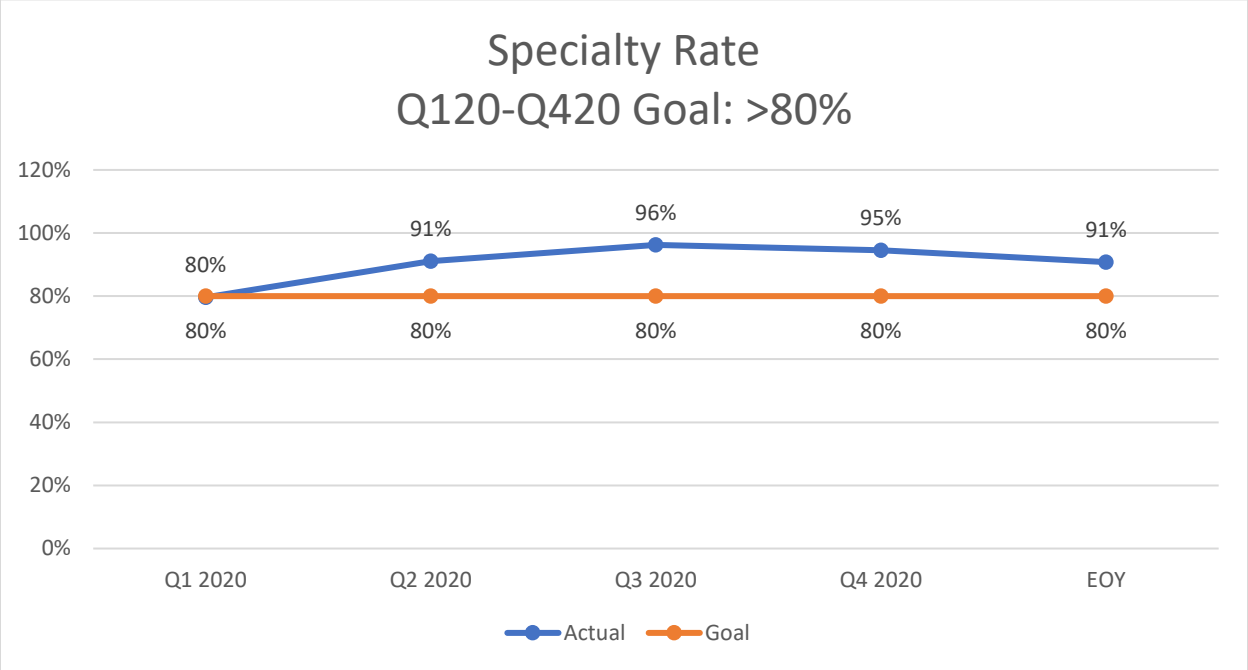
Access and Availability

QI20.16 Improve access to specialty practitioners

Goal: ≥ 80% of specialty care authorizations will be scheduled within 10 business days in 2020

Goal: Met

Data/Analysis: The 2020 rate was 91%.



Summary and Key Findings/Opportunities for Improvement:

This past year, we re-structured some activities associated with our clinic services. One area of redesign was the expansion of staff dedicated to scheduling specialty appointments. This task is rather complex in that the staff member not only schedules the appointment for the participant, but also handles appointment confirmation, coordinating transportation needs, and submitting relevant medical records to the specialist. Additionally, we now have a scheduler who is assigned to each of our 5 IDT teams and focuses on coordinating all these activities.

Pre-pandemic, we continued to have an optometrist and dentist on-site as well as a nurse practitioner dedicated to primary care podiatry issues. This greatly enhanced specialty access, particularly for our diabetic participants. As part of our operational Work Plan for 2021, we will look to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider. Since we historically met our benchmarks in this element, we intend to move our 2021 benchmark from ≥80% to ≥ 84% of specialty appointments scheduled within 10 business days.

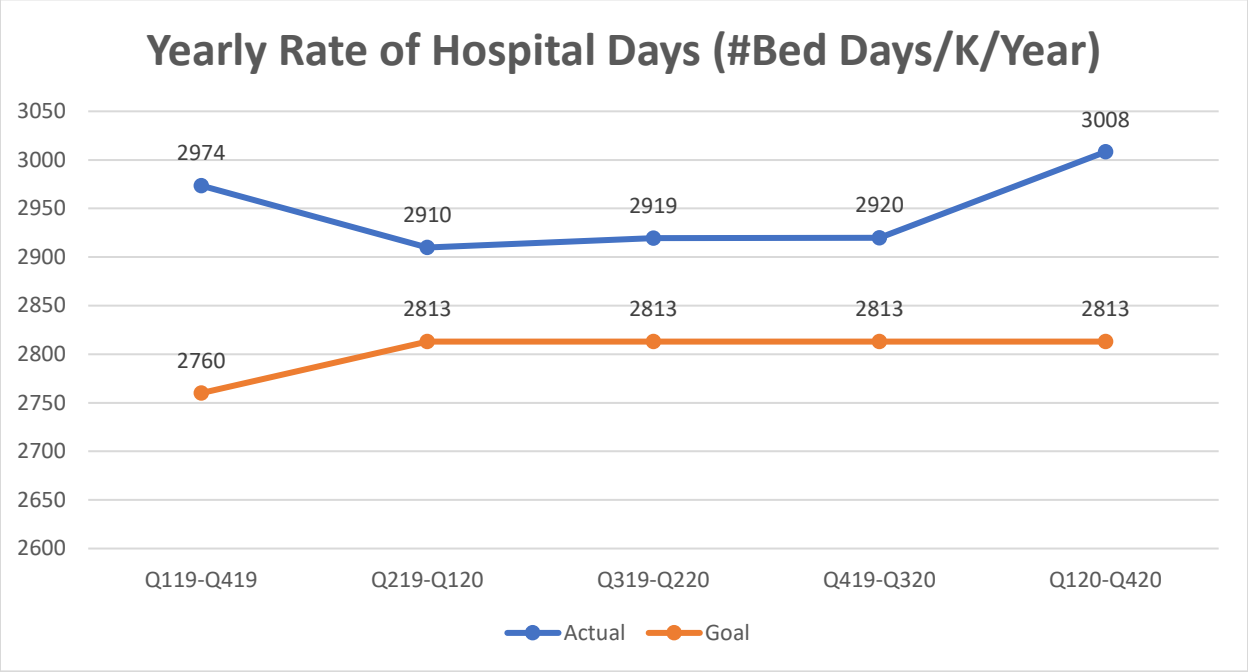
Utilization Management

QI20.17 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,813 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2020 rate was 3,008 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

COVID-19 had a significant impact on our hospitalizations. Our hospital utilization numbers increase over the course of the year, spiking in Q4. The majority of the admissions were for COVID-19 related issues, followed by complications with end stage renal disease and pneumonia.

PACE participants are high risk for being exposed to COVID-19 since many tend to live in crowded living situations and cannot easily be quarantined from others in the home. The majority of PACE participants who were infected with COVID-19, acquired the virus at home. The second highest means of infection occurred in participants who lived in nursing facilities. Initially, one of our strategies in reducing the rate of community acquired transmission was to house the susceptible (i.e. a member of their household tested positive) in a motel. However, this became increasingly difficult to carry-out. The rising COVID-19 infection rates among our patient combined with their comorbidities led to increased rates of hospitalization in 2020.

However, PACE was able to implement strategies aimed at reducing hospitalization of COVID-19 positive participants including:

1. COVID-19 positive participants were contacted on a daily basis for 10 days by their PCP.
2. Pulse oximeters and blood pressure machines were delivered to compromised participants and clinic nurses followed up as needed.
3. Implementation of a telehealth platform to allow participants to virtually engage with PACE providers and staff.

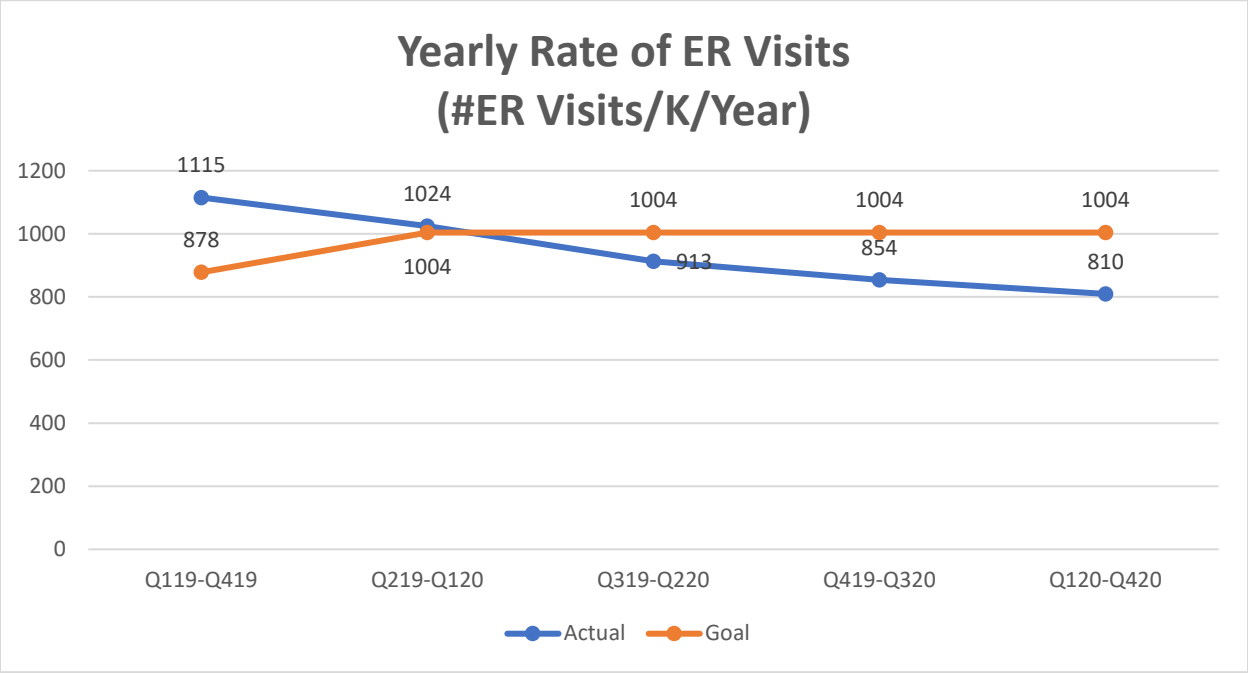
We will continue to monitor our hospital utilization and seek strategies to reduce our numbers in 2021.

QI20.18 Reduce the rate of ER utilization by PACE participants

Goal: < 1,004 emergency room visits per 1000 per year

Goal: Met

Data/Analysis: The 2020 rate was 810 emergency room only visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

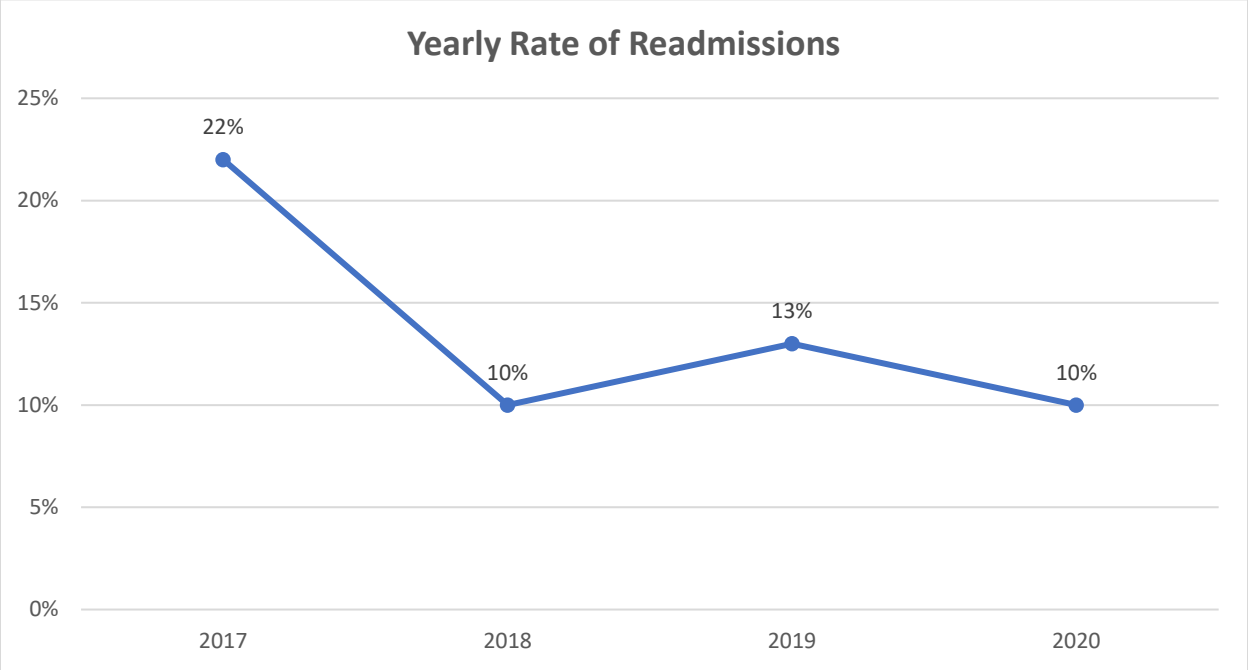
Emergency rooms visits declined throughout the year. Participants became apprehensive about going to the emergency room and risking further exposure to the COVID-19 virus and PACE was communicating with participants regularly through the daily wellness calls ensuring that all medical issues were being addressed in a timely manner and not ignored. We saw an increase in the utilization of our 24-hour on-call physician services, telehealth visits and home visits. Now, with the permanent integration of a telehealth platform into our clinical operations and a reliable and consistent after-hours call service, we hope that the emergency room utilization will continue to trend down even after the pandemic subsides. Our end of the year rate fell below our benchmark and demonstrated a 27% decrease in emergency room utilization from 2019.

QI20.19 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 15% 30-day all cause readmissions

Goal: Met

Data/Analysis: The 2020 rate was 10%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year over year due to the small total number of participants and readmissions. We ended 2020 with a 10% 30-day readmission rate which is a 3% decrease from 2019. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2020, we began incorporating the morning clinical huddles into the interdisciplinary team meetings (IDT). This concept was piloted in Q4 of 2019 with one IDT with great success and was adopted program wide in 2020. Additionally, important measures taken by PACE PCPs aided in our ability to meet our goal to reduce 30-day hospital readmissions. PCPs utilized telehealth to triage participants health needs before they required emergency services, such as following up on wellness calls as necessary and providing telemedicine services though the afterhours clinic line. PCPs also followed up with participants soon after their hospital discharge in order to reassess the participants immediate health needs following hospitalization, as well as any long-term need for changes in care plan to prevent future hospitalizations.

QI20.20 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 3% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: 2020 rate was 1.7% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

One of the main goals of the PACE program is to help our participants continue to live safely at home for as long as possible. We ended the year with 1.7% of our participants who resided in an LTC. This is a slight increase from the 1.3% rate in 2019 but compares favorably to the CalPACE average of all California PACE programs of 3%. However, this is an area that we are monitoring closely as we expect we may see an increase in the upcoming years. There are several issues that are contributing to the rise in PACE LTC census for our high-risk participants, especially for those

with multiple advanced chronic conditions. These are participants whose outpatient management has been unsuccessful in the home, assisted living facility (ALF) or board and care (B&C) environment. Families and caregivers may be unable or unwilling to assist with necessary care tasks at home. Poor family support and fragile living environments can lead to increased ER and hospital utilization. On some occasions, participants need temporary placement in an LTC as a custodial care measure. These are participants with complex medical conditions that require complicated workups, specialty care, and who have difficulty with maintaining their care plan on their own at home. For example, participants who are noncompliant with their prescribed medications, refuse to attend their hemodialysis sessions, or have recurrent falls where all other fall prevention measures have failed. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. Although the number of participants residing in LTC facilities is approximately 1.7%, we recognize that as our program matures, we may see an increase in this percentage.

Enrollment

QI20.21 The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%

Goal: The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%

Goal: Not Met

Data/Analysis: We had 6 controllable disenrollments within 90 days which was 6.98% of the total disenrollment (86 total disenrollments in 2020)

Summary and Key Findings/Opportunities for Improvement:

In 2020, we did not meet our goal of less than 4% controllable disenrollments. Our controllable disenrollment rate for 2020 was 6.98%. We did, however, see a 3.71% improvement over 2019 when the controllable disenrollment rate was 10.71%. In 2020, 6 of our participants disenrolled for controllable reasons with the main reason of wanting to keep their pre-enrollment PCP and/or health plan. In effort to reduce these numbers, data related to disenrollment for controllable reasons is shared with the enrollment team throughout the year. This is done to ensure that the enrollment staff are communicating effectively with participants *prior* to their enrollment, so that participants fully understand the benefits and expectations of the PACE program when enrolling in PACE. In 2021, we will adjust our benchmark to a goal of less than 6.5% of participants disenrolling for controllable reasons. We will continue to monitor and share this information with staff to ensure continuous improvement.

QI20.22 Increase the Qualified Lead to Enrollment conversion rate to 55% in 2020

Goal: Increase the Qualified Lead to Enrollment conversion rate to 55% (5% improvement over baseline)

Goal: Met

Data/Analysis: Final rate was 67%.

Quarter 2020	Rate
Q1	59%

Q2	76%
Q3	64%
Q4	77%
EOY	**67%**

Summary and Key Findings/Opportunities for Improvement:

In 2020, we exceeded our goal in the percentage of qualified leads to enrollment. This afforded the frail and elderly in our community greater access to health care in an environment which also supports their physical, rehabilitative, and psychosocial needs.

Several strategies led to successful enrollment:

1. Revision of our screening, intake, and assessment tools to screen-out enrollees who were too high-functioning and would not be eligible per State certification, although they initiated an inquiry.
2. Utilization of data indicating origins of referrals to PACE.
3. Redesigned marketing collateral, which educated the community in the benefits of enrolling in PACE.

Transportation

QI20.23 and QI20.24: Transportation

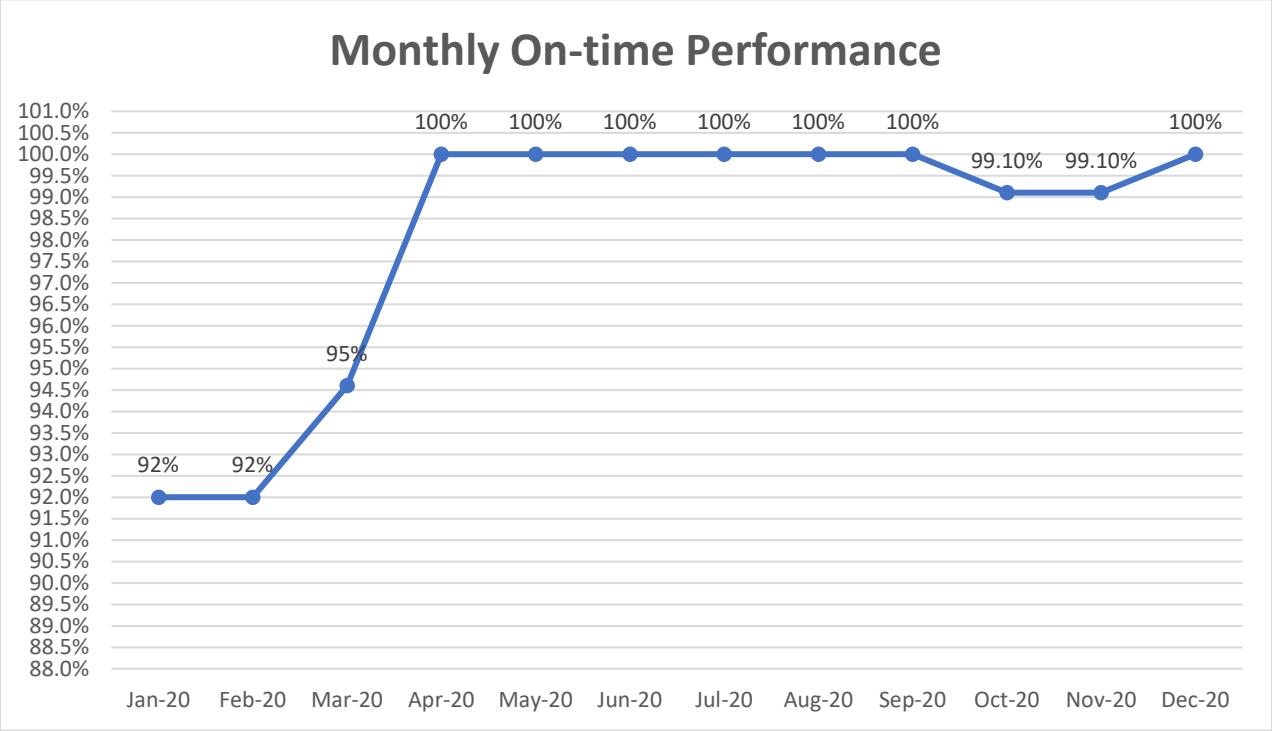
Goal: Ensure PACE transportation ride times are less than 60 minutes per trip with a goal of 0 trips > 60 minutes in duration, and improve participant experience by providing timely transportation services with a goal of ≥ 92% on-time performance.

Goal: Met

More than 60 minutes in ride duration: 0 trips
On-time performance: ≥ 92%

Data/Analysis: 2020 data

More than 60 minutes in ride duration: 0 trips
On-time performance: 98%



Summary and Key Findings/Opportunities for Improvement:

Significant operational changes within the transportation department occurred in March 2020:

1. A transportation coordinator was hired to improve efficiency/oversight and participant satisfaction.
2. A new in-house tracking system was implemented which monitored late trips and outside appointments which may have been extended, and any other delays. This system allowed for solutions to problems in real-time.
3. Comprehensive reports and meetings were held monthly to address concerns. These operational changes allowed us to meet our goals in on-time performance and maintaining trips under 60 minutes.

Prior to the onset of the pandemic, PACE transportation provided over 6,200 trips for our participants monthly. As we began to curtail day center attendance in mid-March and eliminate non-essential specialty appointments, the activities of our transportation department were realigned to meet the new needs of participants. For quarters 2–4, our transportation department redirected their efforts to other PACE related services such as providing transportation services for drive-through immunization and COVID-19 testing, delivery of care packages and durable medical equipment. Despite the decrease in transportation demands, April through December 2020 still averaged 2,070 monthly trips. For the year, transportation completed 35,967 one-way trips with an on-time performance of 98%. We will continue to actively monitor trends in transportation, not just in terms of on-time-performance, but also for participant satisfaction.

Meals

QI20.25 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 71% on Satisfaction with Meals summary score on the 2020 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 80% overall weighted participant satisfaction summary score.

2020 Participant Survey Satisfaction with Meals Domains

Domain	2019	2020	2020 National Average
Do the lunches look good?	75%	81%	69.5%
Do the lunches taste good?	72%	75%	61.9%
Do you get a variety of foods here?	85%	78%	81.1%
Meal satisfaction composite score	77%	78%	70.7%
Overall, would you rate the lunches as excellent, very good and/or good?	81%	**80%**	79.0%

Summary and Key Findings/Opportunities for Improvement:

In 2020, we met our benchmark with 80% of PACE participants indicating satisfaction with their meals, exceeding the PACE national average of 79%. In 2020, we engaged the services of a research entity which surveyed participant satisfaction for PACE programs statewide. One of the domains surveyed was a participant's satisfaction with meals. Survey responses indicated that participants were generally satisfied with meals provided by PACE. In 2019–2020, we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants. As the pandemic emerged in March 2020 and we no longer provided day center attendance, we began home delivered meals. For the months of April through December of 2020, we provided an average of more than 2,000 meals per month for a total of 32,785 in 2020.

Most participants indicated that the meals looked appealing, tasted good and were varied. Our dietary team monitored participant meals, frequently adjusting menus to be consistent with therapeutic diet parameters as well as an individual's preference. We will continue to monitor this domain in 2021.

Overall Satisfaction

QI20.26 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: Greater than or equal to 89% on the Overall Satisfaction Weighted Average on the 2020 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 89% overall weighted participant satisfaction summary score.

Participant Survey Overall Satisfaction Domains

Domain	2019	2020	2020 National Average
Would you recommend the program to a close friend or relative?	96%	91%	92.9%
Overall satisfaction with the care received	96%	88%	94.6%

2020 Participant Survey Domains

Domain	2019	2020	2020 National Averages
Transportation	96%	95%	94.0%
Center Aids	94%	96%	90.6%
Home Care	89%	90%	86.5%
Medical Care	93%	91%	90.7%
Health Care Specialist	98%	87%	89.7%
Social Worker	96%	93%	94.6%
Meals	77%	78%	70.7%
Rehabilitation Therapy and Exercise	98%	87%	93.3%
Recreational Therapy	91%	85%	80.1%
Environment and Safety	93%	85%	87.5%
Weighted Summary Score	92%	**89%**	88.3%

Summary and Key Findings/Opportunities for Improvement:

In fall 2020, CalOptima PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 111 participants via telephone, to gauge the participant's satisfaction with CalOptima PACE services. This is a standardized survey taken by most of the PACE programs in the country.

The overall satisfaction score was 89%, with 91% of our participants indicating they would recommend PACE to a close friend or relative. High marks were given to our center aides, transportation, medical team, home care, and social work departments. It does appear that the pandemic did impact our scores as this was a decrease from our score of 96% in 2019. We saw a decrease in scores in the areas whose face-to-face services were decreased during the pandemic including rehabilitation and exercise, recreational therapy, and the heath care specialist. We will look at additional ways to provide participants services as the pandemic continue. However, we

expect our scores to increase as participants are allowed to come back to the center and receive the services in the way they had prior to the pandemic.

SECTION 5: 2020 HEALTH PLAN MANAGEMENT SYSTEM (HMPS)

2020 HPMS Updates: In 2018, CMS implemented changes to the Level I event and Level II reporting structure. Level I and Level II events are now referred to as Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

1. Grievances
2. Appeals
3. Unusual Quality Incidents
4. Medication Errors
5. Immunizations (evaluated in the Quality of Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

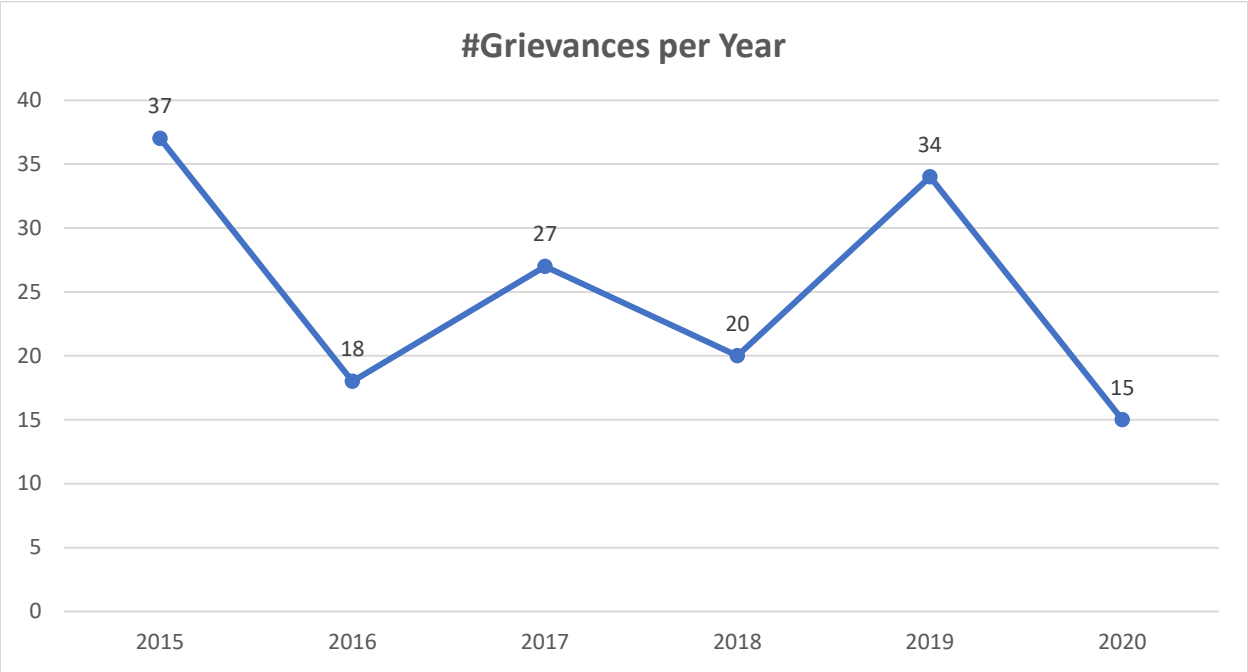
Grievances

Data Analysis:

Quarterly Grievances Q1 2019–Q4 2020

	CENTER							CLINIC			
					Transportation			Clinical Care/			
	# Grievance	Other	Food	Home Car	Timeliness	Prt-Driver	Escort	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q1 2019	2	0	0	0	1	0	0	0	0	1	0
Q2 2019	9	0	0	0	8	0	0	0	0	1	0
Q3 2019	14	7	0	0	4	0	1	0	0	0	2
Q4 2019	9	0	0	2	4	0	0	1	0	1	1
Q1 2020	4	1	0	0	2	0	1	0	0	0	0
Q2 2020	1	1	0	0	0	0	0	0	0	0	0
Q3 2020	2	0	0	0	0	0	0	1	0	1	0
Q4 2020	8	0	0	0	2	1	0	2	1	1	1

Grievances Per Year 2015–2020



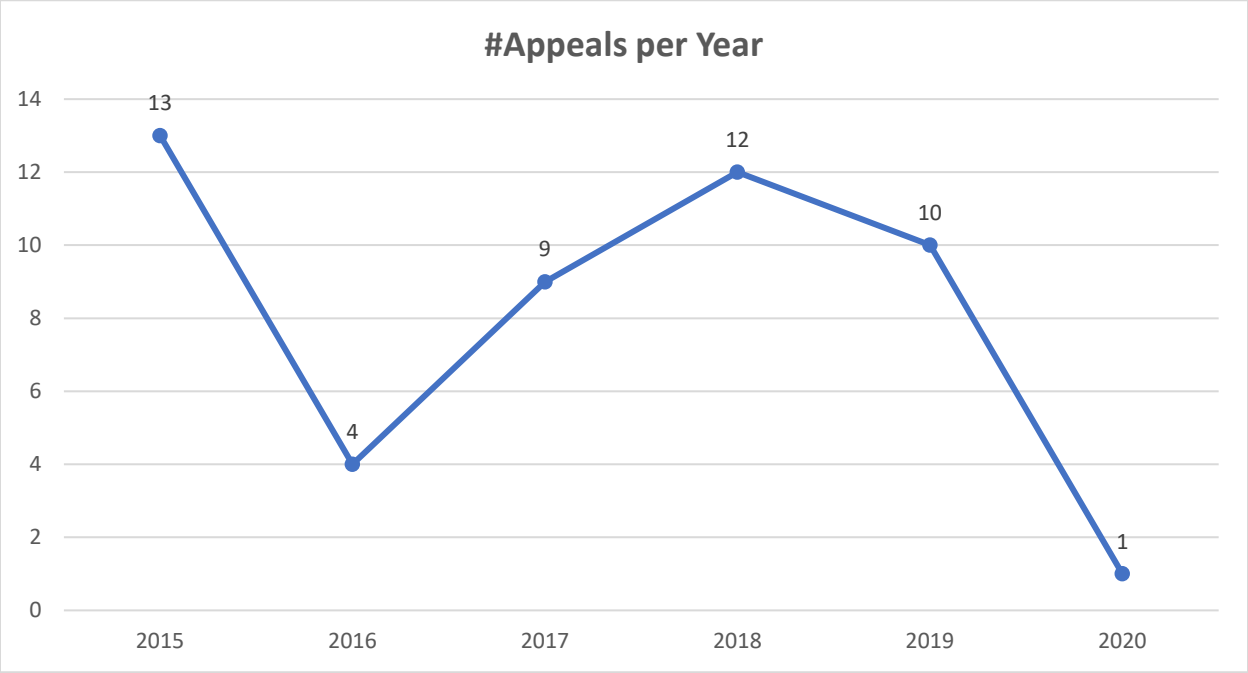
In 2020, we saw a 55% decrease in the number of grievances filed by participants. This is somewhat to be expected during the pandemic restrictions since participants were under stay-at-home orders. Most of the grievances were transportation related issues such as being picked up late or drivers arriving at the participant home too early. Despite this, our participant satisfaction survey revealed that 95% were satisfied with transportation services. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period.

The majority of participants filing grievances are satisfied with the resolutions. As with previous years, we will continue to monitor and observe for trends with grievances filed.

Appeals

Data Analysis:

Appeals Per Year 2015–2020

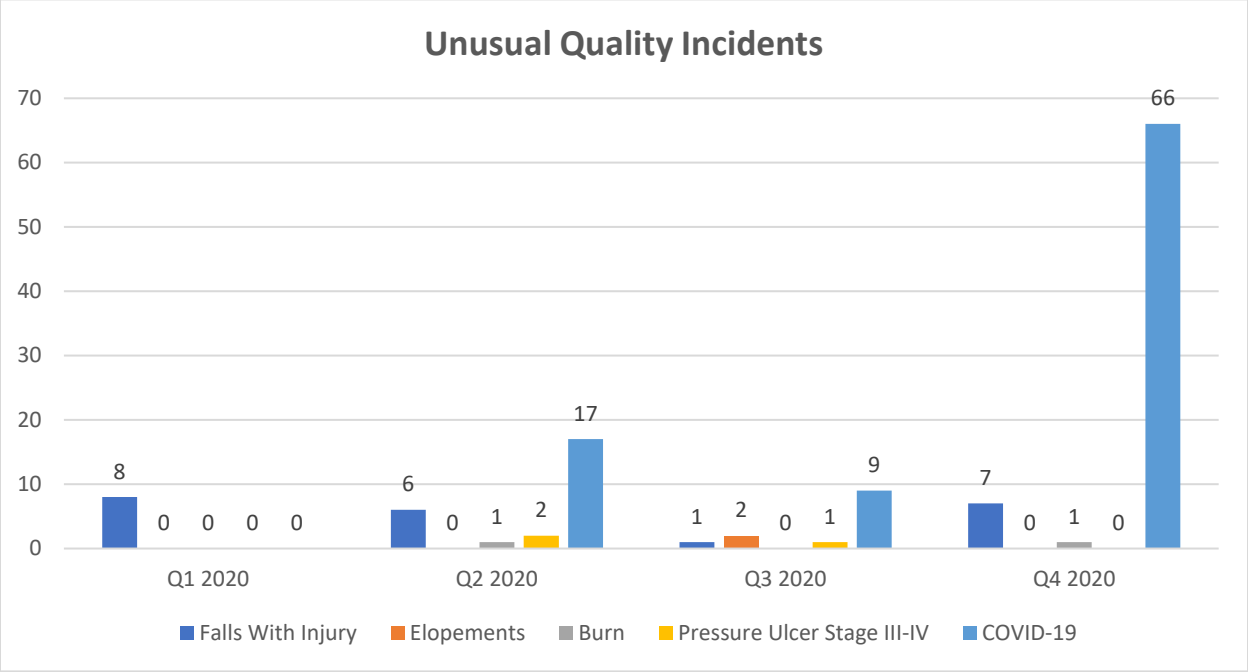


Appeals by participants continue to be minimal in 2020. Only 1 appeal was submitted in 2020 and a third-party review team upheld CalOptima PACE's IDT's decision. This is in part due to the time the team takes in explaining the reasons for denials to our participants and ensuring all their questions are answered.

Level II Events/Unusual Quality Incidents

Description of Level II Events: Unusual quality incidents (formerly referred to as Level II events) are monitored by the PACE QI team. Unusual quality events including falls with injury, elopements, burns, pressure ulcers (stage III–IV) and infectious disease outbreaks and are reported to CMS and DHCS on a quarterly basis. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All unusual quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed on each incident. The RCA begins with the QI team investigating the incident (what, where and when), followed by a meeting of appropriate disciplines such as nursing, social worker, rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented. In some instances, interventions could include systemic or operational failures that need remediation. In 2019, there was one quality incident which led to an operational change and in 2020, no quality incidents required an operational change.

Data Analysis: See graph below



Falls with injury are usually the most prevalent unusual quality event at PACE. As the stay-at-home orders were mandated, participants sustained more falls in their home, usually during transfers. The number of falls however did not increase significantly from 2019. As with the previous year, the falls are either a result of non-use of durable medical equipment or lack of family supervision. In 2020, due to the COVID-19 pandemic, we saw an increase in reporting of infectious disease cases under unusual quality incidents, especially in quarter 4. An RCA was conducted after each unusual quality incident.

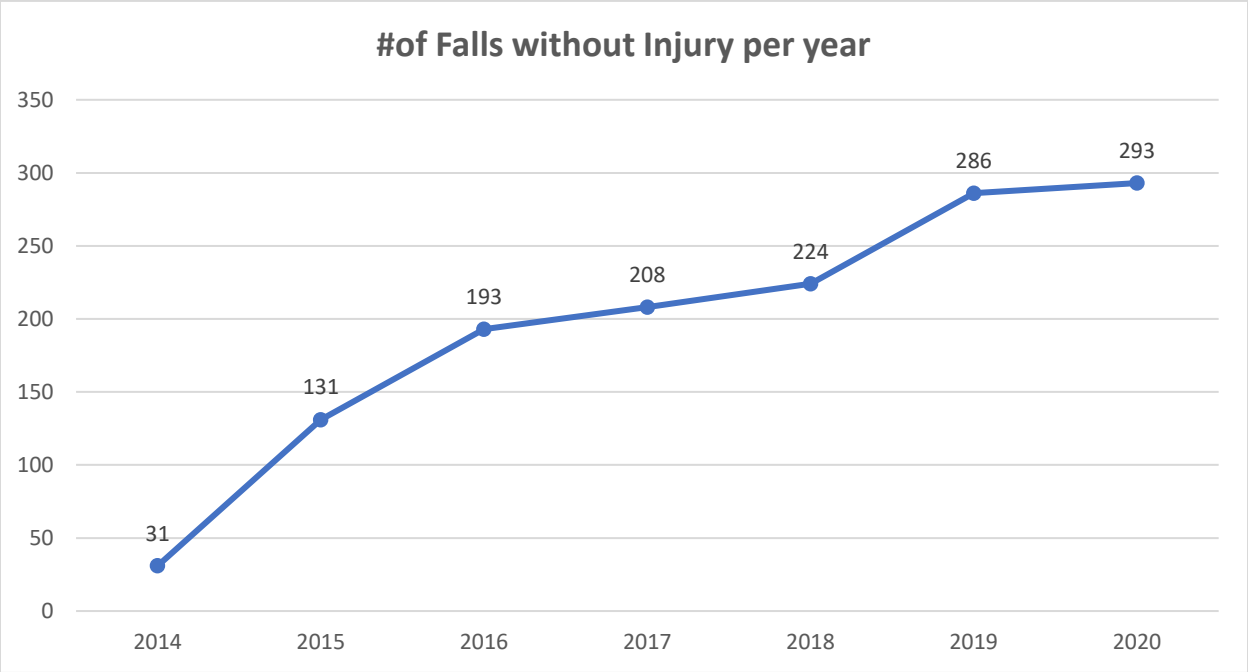
Medication Errors

A total of 3 medication errors were reported in 2020 which reflects a 50% decrease from the previous year. Two of the medication errors were attributable to staff errors and errors in transcription. In response to the staff errors, education and training were implemented. Another error was made by our contracted pharmacy. In this case, we requested a corrective action plan from the pharmacy, and they complied with this request. No further incidents have occurred.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2020



As in previous years, we have continued to maintain the low number of falls. In 2020, we saw a slight 2.4% increase from 2019 figures, however, this corresponds to the increase in membership. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal to decrease in the numbers of falls in 2020 and continuing into 2021. Ongoing falls prevention groups include:

1. *PACE Fall Committee*: Comprised of PACE rehabilitation staff which reviews those participants who have incurred a fall.

2. *PACE Fall Prevention*: Comprised of PACE participants who are educated by the rehabilitation staff in fall recovery mechanisms.

3. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the rehabilitation team to discuss safety in the home and environment.

4. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

In addition to the above, one of our clinic physicians adopted the Fall Risk Assessment Tool (FRAT) to be used during IDT meetings where participants with recurrent falls are discussed. This predictive tool analyzes risk factors for falls in the elderly population by assessing a participant's medication regimen, psychological status (depression, anxiety) and cognitive status (i.e. dementia). Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, collaborate to develop participant-specific strategies for fall prevention.

Denials of Prospective Enrollees

Two prospective enrollees were denied enrollment by the State.

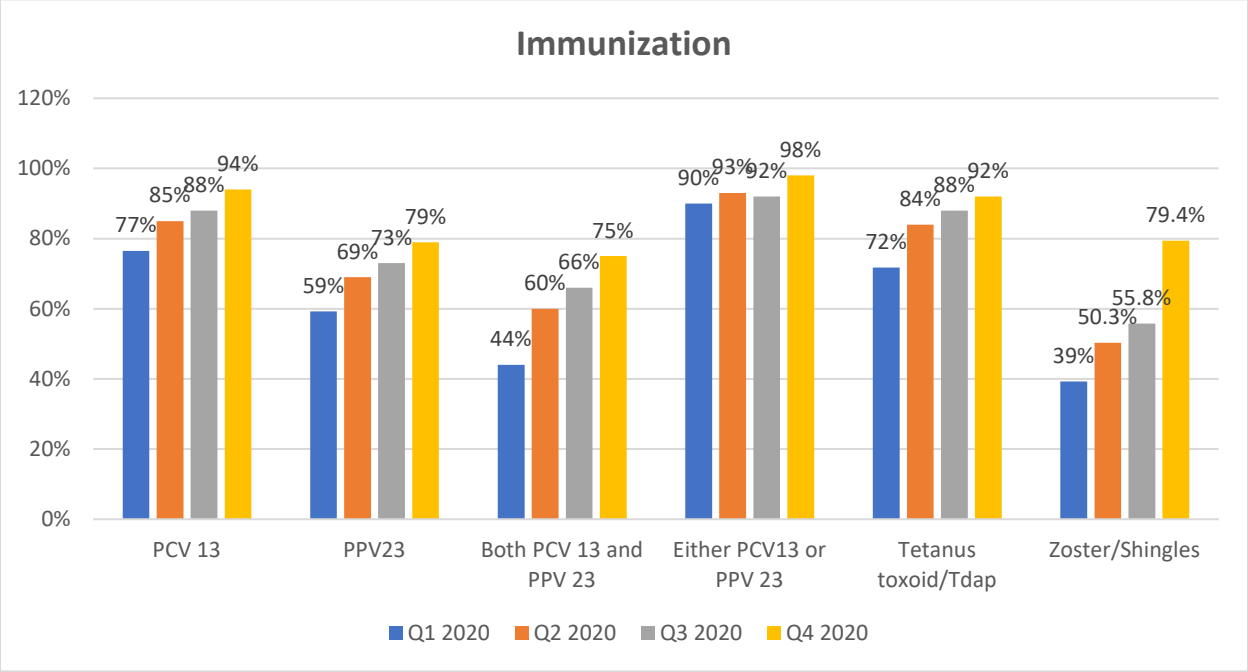
Quality Initiatives

In 2020, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes:

1. **Immunization Dashboard:** With a robust approach in disease prevention, the PACE clinical team rolled-out an aggressive immunization initiative, particularly for the Prevnar 13 and the Pneumococcal 23 vaccines. The elderly PACE population is at an increased risk of contracting pneumococcal disease and the disease itself is highly contagious among the elderly. Optimally, we would like to have participants vaccinated with both vaccines per CDC recommendation. The immunization initiative is a collaborative effort by the QI team and clinical operations.

   Monthly reports are generated by the QI team, specifying participants who require not only the pneumococcal vaccines, but the tetanus/diphtheria and shingles vaccine as well. This report also captures those participants who have refused the vaccines in the past. The clinical director receives these reports and distributes them to the medical providers who are responsible for participants who are assigned to their team. Participants are then called and scheduled for vaccine administration either within the clinic or through our drive-in immunization services. Participants who continue to refuse the vaccines are scheduled for an appointment with their PCP at which time the physician will discuss the importance of the immunization as a part of overall health goals.

   The graph below illustrates our achievements in vaccinating our participants throughout 2020. In respect to vaccinating with both pneumococcal vaccines, our efforts showed a 31-percentage point increase over the 4 quarters of 2020. Other vaccines such as the shingles and Tdap vaccines also showed significant successes in vaccination rates. We will continue with this initiative in 2021.



2. **Advance Health Care Directive:** Provided participants the opportunity to complete an advance health care directive, thereby designating a medical decision-maker in the event that the participant is unable/incapacitated to make such a decision. From the months of June through November of 2020 we reached out to participants and educated them on the purpose of the advance health care directive and upon request, provided assistance to complete the directive. We offered notary services, and PACE transportation was provided to center so that social workers could answer participant's questions. The original documents were provided to the participant and a copy was uploaded into their medical record. Prior to the implementation of the initiative, only 15% of the participants had an advance health care directive or a durable power of attorney. Post-initiative, 39% of the participants have a notarized advance health care directive.

   Looking forward into 2021, we intend to offer this service at the time of enrollment into the PACE program.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2021

1. **Improve the Quality of Care (QOC) for Participants**
   a. Addition of new COVID-19 immunization element to ensure all participants get vaccinated.
   b. Continue to expand telehealth services, drive through clinics, and home visits.
   c. Refine new clinical triage workflow.
   d. Further develop the operational/utilization dashboard to reflect the oversight needed as PACE expands ACS partners.

2. **Ensure the Safety of Clinical Care**
   a. The QI team will continue to focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board

and care facilities and transportation.

b. The grievances and potential quality issues involving downstream vendors will continue to be tracked and trended to assure no service or clinical trend is emerges.
c. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.

3. **Ensure the Appropriate Use of Resources**
    a. Inpatient/ER Utilization
        i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk dialysis participants.
        ii. Continue to refine the ER Diversion program.
    b. Specialty Care
        i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care, and attend some IDT meetings.
        ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
    c. Staffing
        i. Continue refinement of the staff relative value units (RVUs) to monitor staff productivity.

4. **Improve Participant Experience**
    a. Participants will be updated on the satisfaction survey process.
    b. The PACE QI team will survey a sample of participants semi-annually and use the metrics as a lead indicator and help find opportunities for improvement.
    c. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.
    d. Once participants return to the PACE day center, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.
    e. Increase the number of participants who have a completed advanced health care directed.

5. **Ensure Appropriate Access and Availability**
    a. Expanding the number of ACS sites will continue to be considered in 2021.
    b. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care, and attend occasional interdisciplinary care team meetings.
    c. Bring back specialists back into the clinic once the pandemic ends.

SUMMARY

CalOptima PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to

live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

APPENDIX: 2020 PACE QI EVALUATION

2020 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI20.01	Improve the Quality of Care for Participants	**2019 PACE QAPI Plan and Work Plan Annual Evaluation**	2019 PACE QAPI Plan will be evaluated by March 1st, 2020	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2020	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QI20.02	Improve the Quality of Care for Participants	**2020 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2020	QI Planand QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2020	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QI20.03	Improve the Quality of Care for Participants	**Influenza Immunization Rates**	>/= 94% of eligible participants will have their annual influenza vaccination by December 31st, 2020	Improve compliance with influenza immunization recommendations	Q3 and Q4 2020	12/31/2020	PACE Clinical Operations Manager	90%	Not Met	N/A	N/A	N/A	N/A	93%	Not Met	93%	Not Met
QI20.04	Improve the Quality of Care for Participants	**Pneumococcal Immunization Rates**	>/= 94% of eligible participants will have had their pneumococcal vaccination by December 31st, 2020	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2020	PACE Clinical Operations Manager	90%	Not Met	93%	Not Met	94%	Met	98%	Met	98%	Met
QI20.05	Improve the Quality of Care for Participants	**Infection Control**	In 2020, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2020	PACE Clinical Operations Manager	2.21	Met	1.17	Met	0.52	Met	2.24	Met	1.55	Met
QI20.06	Improve the Quality of Care for Participants	**Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment**	>/=95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2020	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2020	PACE Center Manager	99%	Met	95%	Met	94%	Not Met	90%	Not Met	94%	Not Met
QI20.07	Improve the Quality of Care for Participants	**Care for Older Adults (COA): Functional Status Assessment**	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2020	PACE Center Manager	100%	Not Met	100%	Met	100%	Met	100%	Met	100%	Met
QI20.08	Improve the Quality of Care for Participants	**Diabetes Care**	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director	72%	Not Met	74%	Not Met	84%	Met	87%	Met	87%	Met
QI20.09	Improve the Quality of Care for Participants	**Diabetes Care**	> 85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020		96%	Met	97%	Met	99%	Met	98%	Met	98%	Met
QI20.10	Improve the Quality of Care for Participants	**Diabetes Care**	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020		99%	Met	100%	Met	100%	Met	100%	Met	100%	Met

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI20.11	Ensure the Safety of Clinical Care	Day Center Falls	<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE)	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2020	PACE Center Manager	2.52	Met	0	Met	0	Met	0	Met	0.64	Met
QI20.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director	18%	Met	22%	Met	29%	Met	30%	Met	30%	Met
QI20.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director	0%	Met	2.6%	Met	2.7%	Met	2.7%	Met	2.7%	Met'
QI20.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2020	The PACE QI Department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2020	PACE Clinical Medical Director	1out of 2 had f/u (50%)	Not Met	0 out of 2 had f/u (0%)	Not Met	1 out of 1 had f/u (100%)	Met	2 out of 2 had f/u (100%)	Met	4 out of 7 had f/u (57%)	Not Met
QI20.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	>/=90% of participants will have their medications reconciled within 30 days of hospital discharge in 2020	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2020	PACE Pharmacist	98%	Not Met	100%	Met	100%	Met	100%	Met	99%	Met
QI20.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	>/= 80% of specialty care authorizations will be scheduled within 10 business days in 2020 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2020	PACE Clinical Operations Manager	80%	Met	91%	Met	96%	Met	95%	Met	91%	Met
QI20.17	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	< 2,813 hospital days per 1000 per year (5% decrease from 2019)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director	2910	Not Met	2919	Not Met	2920	Not Met	3008	Not Met	3008	Not Met
QI20.18	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	< 1,004 emergency room visits per 1000 per year (10% decrease from 2019)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director	1024	Not Met	913	Met	854	Met	810	Met	810	Met
QI20.19	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<15% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2020	PACE Medical Director	12%	Met	5%	Met	15%	Met	6%	Met	10%	Met

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI20.20	Ensure Appropriate Use of Resources	Long Term Care Placement	<3% of members (July 2019 CalPACE average) will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Center Manager	2%	Met	2%	Met	2%	Met	1%	Met	1.7%	Met
QI20.21	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager	18%	Not Met	4%	Met	0%	Met	0%	Met	7%	Not Met
QI20.22	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 55% in 2020 (5% improvement over baseline)	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager	59%	Met	76%	Met	64%	Met	77%	Met	67%	Met
QI20.23	Improve Participant Experience	Transportation	l00% of transportation trips will be less than 60 minutes in 2020	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2020	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI20.24	Improve Participant Experience	Transportation	>/= 92% of all transportation rides will be on-time in 2019	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure acurracy of reported times.	Quarterly	12/31/2020	PACE Center Manager	95%	Met	100%	Met	100%	Met	99.40%	Met	98%	Met
QI20.25	Improve Participant Experience	Increase Participant Satisfaction with Meals	>/= 71% on Satisfaction with Meals summary score (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2020	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	78%	Met
QI20.26	Improve Participant Experience	Increase Overall Participant Satisfaction	>/=89% on the Overall Satisfaction Weighted Average (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2020	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%	Met

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887

Recommended Action

Recommend Board of Directors approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a Program of All-Inclusive Care for the Elderly (PACE) Provider on October 7, 2010. The CalOptima PACE program opened in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents. As of December 31, 2020, CalOptima PACE had 395 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.

Discussion

The 2021 CalOptima PACE QI Plan is based on CalOptima's seven full years of data collection, review and analysis with specific data driven goals and objectives. The COVID-19 pandemic had a significant impact on the program's operations in 2020 as its day center closed for most of the year to limit congregating of our high-risk population of participants. Although the PACE clinic remained open, PACE developed and implemented the "PACE without Walls" program, which provided most of the participants' services in their home. This allowed for the continuation of existing PACE care services outside the PACE facility, including nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services, and personal care services. This led to more than 20,000 daily wellness calls, nearly 33,000 home delivered meals and monthly care package deliveries.

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The clinic established drive-through immunization clinics, a new telehealth platform, and increased the number of home visits.

The Work Plan elements were developed based on the opportunities for QI that were revealed in the 2020 CalOptima PACE QI Plan Evaluation. Three new QI Work Plan goals were added for 2021. Two of the elements focus on COVID-19 related issues by monitoring the COVID-19 immunization rates and engagement in telehealth. The final new element is monitoring the completion of an advanced health care directive. In addition, two of the 2020 elements were modified. We expanded the falls element to include the falls that occur at home as our participants stopped coming to the day center during the pandemic, and we reduced the opioids at high dosage element to include those participants taking an average of 90 MME/day or more, rather than 120 MME/day. PACE added two new quality initiatives in 2021. The COVID-19 Vaccine Quality Initiative will focus on vaccine education and outreach as well as the coordination of vaccine distribution with a goal of getting at least 90% of eligible participants vaccinated by the end of March 2021. The Telehealth Expansion Quality Initiative will focus on accelerating the adoption and utilization of telehealth services by our PACE participants. This will involve education, training and ensuring our participants have the hardware necessary to access our telehealth platform. Overall, the number of Work Plan elements increased from 26 to 29 in 2021. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommended action to approve the 2021 CalOptima PACE QI Plan does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-–22 Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a QI program. Through the Code of Federal Regulations (CFR), 42 CFR section 460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE organizations to have their QI Plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR section 460.132(a) and (b), the PACE organization leadership presents their QI Plan and any revisions to their governing body for annual approval to ensure effective organizational oversight. CMS and the state will review the plan during subsequent monitoring visits.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee (Anticipated February 25, 2021) Approved 2/25/2021

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Attachments

1. Proposed 2021 CalOptima PACE Quality Improvement Plan Description
2. PowerPoint Presentation – 2021 PACE QI Plan Description
3. Appendix A — Proposed 2021 CalOptima PACE QI Work Plan

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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CalOptima Program All-Inclusive Care for the Elderly (PACE)

2021

Quality Improvement Plan Description

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PACE CalOptima
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SIGNATURE PAGE

PACE Quality Improvement Subcommittee Chairperson:

Miles Masatsugu, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, M.D. **Date**

Board of Directors Chairperson:

Andrew Do **Date**
Supervisor, First District

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QI Plan is developed by the PACE QI Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for QI and will drive appropriate additions or revisions in the QI Plan and to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.
    - Ensure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant experience.**
    - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
    - Provide education to staff on the multiple dimensions of patient experience.
    - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directive which honors members' wishes as well as advance directive rights.

- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions to identify high-risk members and opportunities for improvement.
    - Review documentation and coordination of care for participants receiving care in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.

- **Ensure the safety of clinical care**
    - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for QI.
    - Monitor and track falls occurring in the PACE day center and in the home and within the community.
    - Monitor and track the use of opioids at high dosages.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of care are met.

- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
    - Monitor and analyze access to specialty care
    - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

The CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's QI Committee (QIC) described in CalOptima's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible for allocating operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE QI Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once per quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that has been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director, who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director, or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director, or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance goals are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that may indicate significant over/under utilization.

Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE

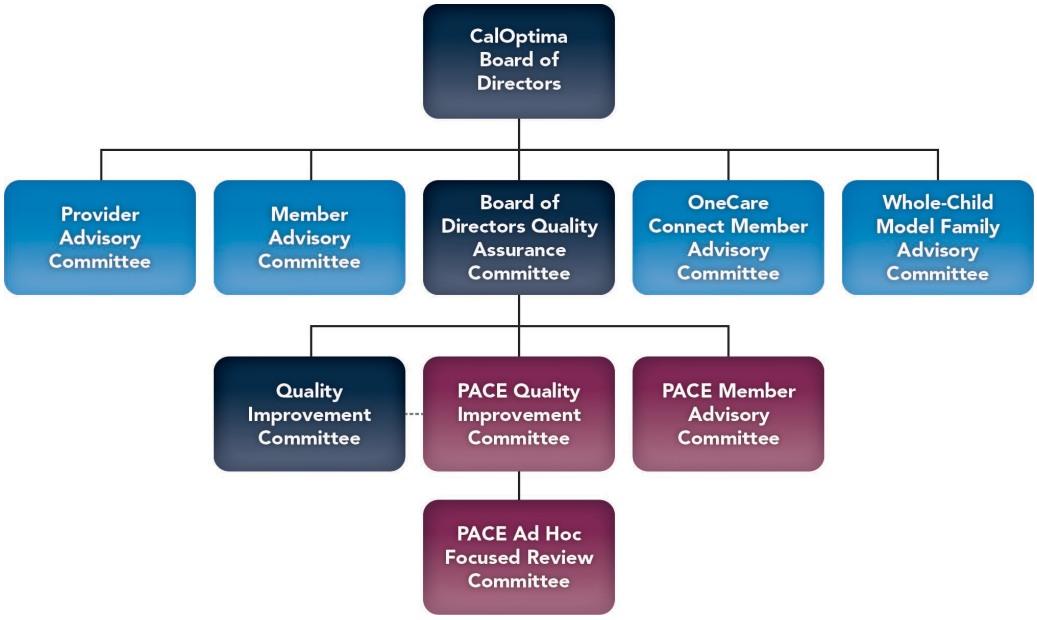
Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
PMAC provides recommendations to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to PMAC membership is disseminated through announcements at the PACE day center floor and all interested participants are invited to join, but must contact their social worker to be placed on the committee. The PACE Quality Improvement Department maintains a roster of active PMAC committee members. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence. PMAC meets on a quarterly basis.

2021Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
    - Hospital Bed Days
    - ER Visits
    - 30-Day All-Cause Readmissions
    - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.
- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant HPMS Data

- Unusual Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan goalss which include:
    - Influenza and Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2021
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2021
    - Infection Control: Respiratory Infection Rates
    - Advanced Health Care Planning: POLST Completion
    - Advance Health Care Planning: Advanced Health Care Directive Completion
    - Functional Status Assessment Completion
    - Day center falls and falls occurring in the participant home or within the community

- Opioids at High Dosage Monitoring
- Medication Reconciliation Post Discharge
- Diabetes Care: Annual Eye Exams
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Enrolled for at least six months during measurement year
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
            - Participants who are 76 years and older as of December 31, 2021
- Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Enrolled for at least six months during 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
            - Participants who are 76 years and older as of December 31, 2021
            - Participants with End Stage Renal Disease
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
            - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Non-aspirin NSAIDS or Cox2 Selective NSAIDs
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI department for investigation, tracking, trending, and data gathering. These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals will be forwarded to the PACE QI department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.
- Telehealth will continue to be integrated as a modality to expand access to care.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with periodic ride-alongs. The times gathered during the ride-alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through periodic participant meal satisfaction surveys as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Potential impact on participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and state administering agencies to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances

- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS), as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture, or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - Any elopement.
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
    - COVID-19 infections
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a CAP will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc., will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's two quality initiatives in 2021 are in response to the COVID-19 pandemic.
    - COVID-19 Vaccine Quality Initiative.
        - This initiative will focus on vaccine education, outreach, and vaccine distribution coordination.
    - Telehealth Engagement Quality Initiative
        - This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX: 2021 PACE QI WORK PLAN

PACE

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2021 PACE Quality Improvement Plan Description

Board of Directors' Special Quality Assurance Committee Meeting

February 25, 2021

Miles Masatsugu, M.D.

Medical Director

2021 PACE Quality Improvement (QI) Plan Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations
- Updates to address the COVID-19 pandemic including the two new 2021 quality initiatives

2021 PACE QI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience
- Additional Focus on COVID-19

2021 PACE QI Eliminated/Modified Work Plan Elements

- Added 3 elements
  - COVID-19 Immunization Rates
  - Advanced Care Planning: Advance Health Care Directive
  - Improve Access to Care: Engagement in Telehealth
- Modify two elements
  - Expanded the falls element to include those occurring at home
  - Reduced Opioids at High Dosage to include those participants taking an average of 90 MME/day
- Total of 29 QI Work Plan Elements in 2021

2021 Quality Initiatives

- COVID-19 Vaccine Quality Initiative
- Telehealth Engagement Quality Initiative

Recommended Action

- Recommend Board of Directors Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan Description

CalOptima's Mission

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


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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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2021 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.01	Improve the Quality of Care for Participants	2020 PACE QAPI Plan and Work Plan Annual Evaluation	2020 PACE QAPI Plan will be evaluated by March 1st, 2021	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
QI21.02	Improve the Quality of Care for Participants	2021 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2021	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
QI21.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2021	Improve compliance with influenza immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Q3 and Q4 2021	12/31/2021	PACE Clinical Operations Manager										
QI21.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2021	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥80% of eligible participants will have had their COVID-19 vaccination by December 31st, 2021	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.06	Improve the Quality of Care for Participants	Infection Control	In 2021, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.07	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2021	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2021	PACE Center Manager										
QI21.08	Improve the Quality of Care for Participants	Advanced Care Planning: Advance Health Care Directive	≥40% of participants will have an Advanced Health Care Directive in place by December 31st, 2021	Ensure all PACE members are offered assistance with the completion of the Advance Health Care Directive	Quarterly	12/31/2021	PACE Center Manager										
QI21.09	Improve the Quality of Care for Participants	Care for Older Adults (COA): Functional Status Assessment	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months. Exclusion: Participants in unstable condition due to a hospitalization. Assessment to be completed upon participant discharge.	Quarterly	12/31/2021	PACE Center Manager									100%	Met
QI21.10	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.11	Improve the Quality of Care for Participants	Diabetes Care	>85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.12	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.13	Ensure the Safety of Clinical Care	Falls at Home or in the PACE Day Center	<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE) ≥17% of participants will not experience a recurring fall within the same quarter	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement. Falls occurring in the home or community will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2021	PACE Center Manager										
QI21.14	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.15	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.16	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2021.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.17	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 30 days of hospital discharge in 2021	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2021	PACE Pharmacist										
QI21.18	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 10 business days in 2021 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.19	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥65% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2021	Community-Based Program Manager										

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.20	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<2,857 hospital days per 1000 per year (5% decrease from 2020)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Clinical Director										
QI21.21	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<807 emergency room visits per 1000 per year (maintain improvements made in 2020)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Clinical Director										
QI21.22	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<15% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2021	PACE Clinical Director										
QI21.23	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Center Manager										
QI21.24	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager										
QI21.25	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60%) in 2021	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager										
QI21.26	Improve Participant Experience	Transportation	l00% of transportation trips will be less than 60 minutes in 2021	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2021	PACE Center Manager										
QI21.27	Improve Participant Experience	Transportation	≥92% of all transportation rides will be on-time in 2021	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2021	PACE Center Manager										
QI21.28	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2021	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.29	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2021	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Tracy Hitzeman, RN, Executive Director, Clinical Operations, (714) 246-8549
Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887

Recommended Action

Recommend approval of the 2020 Utilization Management Program Evaluation and the 2021 Utilization Management Program Description

Background

CalOptima's Utilization Management (UM) Program describes how medically necessary and quality health care services are delivered to our Members in a coordinated, comprehensive, and culturally competent manner. The program ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does it encourage decisions that result in underutilization. Additionally, the UM Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") is reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes processes for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2021 UM Program Description to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory, contractual and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

Discussion

The 2021 Utilization Management Program is based on the Board-approved 2020 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) important aspects of care and service for all lines of business. It is consistent with regulatory and contractual requirements, NCQA standards and CalOptima's own Success Factors.

The revisions are summarized as follows:

1. Included initiatives to mitigate the impact of the COVID-19 public health emergency on the mental health of CalOptima Members and of health care inequities by race and ethnicity.

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2. The transition of Medi-Cal outpatient pharmacy benefits to Medi-Cal Rx, currently planned to be effective April 1, 2021.

3. CalOptima's Health Homes program will support a sustained relationship with current providers of housing-related services and includes the one-year extension of the Orange County Whole Person Care pilot program.

4. Expansion of the Behavioral Health Integration responsibility to include outpatient and inpatient mental health care, and opioid and alcohol misuse screening and counseling, for CalOptima OneCare and OneCare Connect Members.

5. Added role of a Physical Therapist specializing in custom Durable Medical Equipment evaluation and quality monitoring nurses for UM activities and updated the description of responsibilities for various key positions.

The changes recommended to CalOptima's UM Program are reflective of current clinical operations and are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2020 UM Program Evaluation and the 2021 UM Program Description does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

Concurrence

CalOptima Utilization Management Subcommittee
CalOptima Quality Improvement Committee
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee (Anticipated February 25, 2021) Approved 2/25/2021

Attachments

1. CalOptima Annual Review 2020 UM Program Evaluation _2021 Description
2. 2020 UM Program Evaluation
3. 2021 UM Program DRAFT FINAL redline
4. 2021 UM Program DRAFT FINAL clean

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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Annual Review: 2020 UM Evaluation & 2021 UM Program

Board of Directors' Special Quality Assurance Committee Meeting

February 25, 2021

Tracy Hitzeman, RN, CCM

Executive Director Clinical Operations

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Utilization Management (UM) Program and Evaluation

- Annually, CalOptima evaluates the effectiveness of the UM Program:
  - Program structure
  - Responsibility for the UM program
  - New initiatives/programs, and
  - Program scope and processes used to determine benefit coverage and medical necessity
- Based upon the evaluation, the program is revised and updated for the following year
- The 2020 UM Evaluation and 2021 UM Program have been reviewed and approved by the Utilization Management Committee (UMC)

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2020 UM Program Evaluation

Program Section	Evaluation
Scope	○ New roles and responsibilities: ▪ Custom DME Specialist — Physical Therapist provides in-home assessments for members needing custom DME ▪ Inline Monitoring Nurses — Ensure compliance with internal monitoring activities and identification of opportunities for improvement.
Projects, Programs and Initiatives	○ Implemented auto authorization rules for select initial specialty consults ○ Developed enhanced tools and templates to standardized review processes/reinforced UM principles ○ Enhanced over and underutilization monitoring as a corporate-wide initiative ○ Increased oversight of Post-Stabilization Authorization process to ensure compliance with regulatory requirements

2021 UM Program Evaluation

Program Section	Evaluation
Projects, Programs and Initiatives	○ Implementation of the POD concept for processing prior authorizations ▪ Core group of individuals, Nurses and MAA's, who work as a team to process authorization requests ○ Extended authorization time frames in response to the COVID-19 pandemic ▪ No PA requirement for COVID testing, vaccinations, and related treatments and services ○ Successful transition of management of OC/OCC BH benefits from vendor to CalOptima ○ Retirement of BH Quality Improvement Subcommittee ○ Audit & Oversight Dept (A&O) oversight and monitoring of the health networks ▪ CAPs issued to the HNs in 2020 to improve compliance with regulatory standards.

2020 UM Program Evaluation

Program Section	Evaluation
Performance	○ Variation in UM performance metrics noted for Q2 & Q3 2020 for all LOBs — most likely due to COVID (↑ ALOS, Bed Days/K, Readmits; ↓ ED Use) ○ Referral volumes and online referrals ↑; Fax referrals ↓ ○ Pharmacy and LTSS consistently met TAT ○ IRR completed by all business units making UM decisions at 90% or higher

2021 UM Program Description

Program Section	Change	Rationale for Change
Signature Page	Updated Board QAC and Board of Directors Chairperson	Reflect current Board Committee Members
Program Initiatives: COVID-19	Impact and Mitigation of COVID-19, including adverse impact on mental health and health care inequities by race and ethnicity	Reflect impact of COVID-19 during 2020
WPC	Whole Person Care (WPC) pending approval for program 1 year extension	Include requested extension by DHCS
HHP	Health Homes Program (HHP) CalOptima members will continue their current providers for housing-related services	Added information on continuation of housing related services

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
Homeless Health Initiatives (HHI)	Clinical Field Team/Homeless Care Access Program protocols modified due to COVID-19. Recuperative Care a shared cost for CalOptima and the county.	Reflects updates to HHI
Pharmacy Program	Effective April 1, 2021, Medi-Cal Rx becomes responsible for outpatient pharmacy benefit for all CalOptima Medi-Cal members	Change to Medi-Cal outpatient pharmacy benefit administration
Virtual Care Strategy	Virtual Care Strategy implementation plan described goals are to improve member access and reduce wait times for in-person specialty visits	Addition of Virtual Care Strategy to Program

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
Population Health Management (PHM)	Updated strategy to mange CalOptima's diverse population by expanding the model of care approach, focusing on existing programs, and increasing provider awareness	Updated PHM Program strategy and approach
UM Program Goals	Identification of staff training needs- ensure UM workflow and process change expertise is developed and maintained as the standard	Continuous identification of improvement opportunities
Behavioral Health Integration	Description of mental health services available to OC/OCC members: outpatient and inpatient mental health care, and opioid treatment and alcohol misuse screening and counselling	Accurate description of available services

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
BH Directors: • Integration Clinical • Operations	Described these new roles in the UM Program for Behavioral Health (BH)	Critical for BH success with the OC/OCC transition
BH UM Resource	Update Medical Case Manager role (BH RN)	Update scope of role
UM Resources	Addition of two nurses to monitor departmental processes, ensure compliance to standards, and make recommendations for corrective actions	To maintain compliance with UM processes and improve performance
LTSS Resources	Program Manager to assist with program administration	Resource addition to LTSS program

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2021 UM Program (cont.)

Program Section	Change	Rationale for Change
UM Committee (UMC) Role	Review and recommend actions related to over/underutilization added to UMC role	Include over and underutilization monitoring in scope of UMC
Pharmacy and Therapeutics (P&T) Subcommittee Pharmacy determinations	Updated to reflect Medi-Cal Rx carve-out	Medi-Cal RX carve-out impact to P&T function
Authorization Types	CCS Numbered Letters (NLs) added as a guideline for Whole Child Model (WCM) members	Clarification of criteria used for WCM authorization types

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
Hierarchy of Clinical Decision Making	Updated sequence of criteria used for medical necessity determinations	Clarify protocol for evidence-based guidelines use in the UM process
Over/under utilization	Added Clinical Process Excellence and UMC as participants in monitoring metrics, performance, trends and suggesting actions necessary	Expand agency-wide monitoring of potential over and under utilization
Communications	Detailed process for communications received after normal business hours and response time	Manage expectations of managing communication requests after hours

Our Mission

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

2020 CalOptima Utilization Management Program Evaluation

I. Executive Summary

The 2020 Utilization Management (UM) Program describes CalOptima's activities to provide optimum utilization for members with access to quality health care services delivered in a cost-effective and compassionate manner.

Annually, CalOptima evaluates the UM program structure, scope, processes, an information sources used to determine benefit coverage and medical necessity. This evaluation of UM activity is approved annually by the UM Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

During 2020, we broadened the scope of the UM program to ensure we are adequately meeting our members need, while maintaining compliance with recognized regulatory and accreditation standards. Specifically, we added the following roles:

- Addition of a Custom Durable Medical Equipment (DME) Physical Therapist (PT) to complete in home assessments of members needing custom DME.
- Addition of two (2) inline monitoring nurses to ensure compliance with internal UM activities and identification of opportunities for improvement to achieve and maintain compliance with regulatory and accreditation standards.

The structure and process of the UM department has not changed in relation to UM staff assigned activities. This includes those who have the authority to deny coverage, designated physician and behavioral health care practitioner involvement in the program, evaluation and development and approval of the UM program, process for handling appeals and making appeal determinations, as well as rule out within the organization related to the QI program and QI activities. Additionally, information sources used to determine benefit coverage remained current and appropriate. These are reviewed and approved annually at the UMC.

II. Projects, Programs and Initiatives

A. Utilization Management

In 2020, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. These projects included:

- Upgrades/enhancements to the Guiding (GC) Care Utilization Review Module in CalOptima's medical management system.
- Identifying through data analysis those services that can be automatically authorized in the UM system without clinician review, to improve the throughput time to provide authorizations to members to timely access needed care.

- Development of tools, such as documentation templates for physical therapy, occupational therapy and speech therapy Physical Therapy (PT), Occupational Therapy (OT) Speech Therapy (ST), as well as training focused on improving documentation requirements and UM processes in an effort to improve and maintain compliance with UM requirements.
- Continued development of CalOptima Reporting Environment (CORE) to align operational reports with the data structure in GC and to continue to identify opportunities for process improvement.
- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes.
- Extended authorization time frames, relaxing UM requirements for those members impacted by the public health emergency COVID-19 pandemic, as well as tracking and reporting of positive members, hospitalizations, and deaths.
- Fully developed an organization wide over and underutilization monitoring process to ensure members receive the appropriate care, timely and frequency to keep them well.
- Increased oversight of post-stabilization process to ensure that members requiring post stabilization care are afforded that care and compliant with regulatory requirements.
- Tested to determine if changing our staffing model to a POD approach, or a group of 3 nurses and 3 MAAs, would improve efficiency, consistency, and timeliness of authorization requests, which if successful would be spread to the entire prior authorization department in 2021.

The Medical Director of UM supported the UM process by providing clinical oversight for the administration of the UM Program and was very engaged during this year. He/she also supported the UM process by ensuring that treatment requests were processed in accordance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluated the program's effectiveness against established goals.

For UM Program areas that did not meet the approved goals, modifications to program activities were proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan was presented and approved by the UMC. Those changes were implemented by the UM Leadership and department staff.

The UM Medical Director supported provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This committee evaluates new and modified benefits to determine the need for prior authorization and it led by the UM Medical Director. Those services not requiring PA led to provider and member satisfaction by allowing the provider to administer these services in a timely manner due to not requiring a PA. The UM Medical Director also chaired the bi-weekly UMWG and provided input to the development and processes of UM Program to ensure quality, cost-effective services and care are delivered to CalOptima members. The UM Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, and discussed appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisted with discharge planning management. The director also provided education to the team to ensure understanding of the clinical basis for decisions.

The UM Medical Director also provided focused education on specific topics including genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

The Behavioral Health (BH) Medical Director was also very involved in the UM program development and administration. This was evidenced by providing input on the program to ensure all BH activities were integrated and aligned with the medical program and ensured compliance with UM regulatory and accreditation requirements. The BH Medical Director also participated in the UMWG, UMC and BMSC meetings to ensure adequate representation of BH and ensure that members BH needs are identified, considered and handled appropriately. The BH Medical Director also represented CalOptima at various meetings and collaborations related to the BH needs of the population and transgender services, including Orange county work groups focused on this population and working with Orange County Legal Aid to ensure services are provided to this population. The Director was very involved in the formation and implementation of policies and procedures, to ensure that appropriate changes are made based on state and federal guidance that was received throughout the year such as All-Plan Letters and other sources of regulatory updates.

In 2020, both the UM Medical Director and BH Medical Director supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2020, CalOptima continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination and Quality Improvement (QI). The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines.

For OneCare (OC) and OneCare Connect (OCC), CalOptima successfully transitioned in 2020 the management of behavioral health (BH) benefits from Magellan Health to CalOptima internal operations similar to the structure we have established for Medi-Cal. The BHI department is now directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

The Behavioral Health Quality Improvement (BHQI) subcommittee was retired in 2020. Objectives of this subcommittee were incorporated into CalOptima's committee structure including QIC, UMC, Member Experience Committee (MEMX), and Grievances, Appeals, and Resolutions (GARS) subcommittee. The goal is to further enhance the integration of behavioral health into CalOptima's programs and functions. The BH Medical Director and Directors of Behavioral Health Services participated in QIC and other subcommittees. In addition, Orange County Mental Health Plan Medical Director was added to the QIC membership to promote behavioral health integration for individuals with severe and persistent mental illness. In 2020 the BHQI workgroup continued to meet on a monthly basis to develop and implement BH quality initiatives. This internal group served to address suggestions from QIC and other subcommittees to identify areas of improvement, strengthen interventions, review performance data and improve the member experience.

C. UM Data Management

The UM data report's design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff. Together with UM department subject matter experts, EA and IS maintained a focused effort to improve the understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks

(HNs). Further refinement of data (XML) file format for HN submission of data elements included authorization information that led to increased reliability of reports and improved the usefulness of information. Additional efforts are planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by configuring standard queries of the data mart.

D. UM Delegated Provider Oversight

The external A&O department within CalOptima, provides HN oversight to ensure HN compliance with regulatory requirements. Their oversight is comprised of monthly auditing of UM files, as well as other delegated functions, to ensure compliance. Additionally, it performs an in-depth annual audit of each HN to ensure compliance with CalOptima and regulatory requirements. HN performance is monitored via a monthly delegation oversight dashboard, which is segmented by line of business. This dashboard includes performance for all aspects of A&O monitoring, including UM, as well as the identification of trends. A&O provided corrective action plans (CAPs) to those HN who were not meeting delegation requirements. It is also worth noting that due to the COVID-19 pandemic, it was necessary to suspend some of the monthly audits, which impacts overall performance of the HNs.

Areas of focus for the monthly audits are:

- **Timeliness**: Meeting turnaround time (TAT) for routine and urgent authorization requests related to timeliness of decision and notification. The goal for this metric is 98% or greater.
- **Clinical decision making**: Appropriateness of clinical decision making for authorization requests approved, denied or modified.
- **Notifications**: Compliance with regulatory standards related to member notification of denials by reviewing the Notice of Action sent to the member indicating that the service was denied or modified.

Medi-Cal

HN oversight performance below, reveals that there are opportunities to improve TAT for urgent authorization requests, clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

Medi-Cal 2020 HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=11)	Issues Identified
Routine TAT Timeliness	98.8–100%	11	N/A
Urgent TAT Timeliness	96.45–99.82%	3	Did not meet TAT for urgent authorization requests, as well as member and provider notification timely
Clinical Decision Making	67–100%	3	Failure to cite criteria used in making the medical necessity determination, failure to obtain clinical info to support the request and failure to use the appropriate professional for making the clinical decision

Notifications	75–100%	3	Failure to use lay language to describe why a service did not meet criteria, notifications to member not in threshold language, failure to provide peer-to-peer with medical reviewer and failure to indicate the name and contact information for healthcare professional responsible for the decision to deny

The A&O department issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as, but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations.

OCC

HN oversight performance below reveals that there are opportunities to improve clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

OneCare Connect 2020 HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=10)	Issues Identified
Routine TAT Timeliness	99–100%	10	N/A
Urgent TAT Timeliness	98.57–100%	10	N/A
Clinical Decision Making	33–100%	4	Failure to cite criteria for decision making
Notifications	78–100%	5	Failure to cite criteria for decision, failure to provide notification in members preferred language and lack of lay language description in notification to member.

A&O issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations within regulatory requirements.

OC

HN oversight performance below reveals that there are opportunities to improve TAT, clinical decision making, and notification sent to the members about the decision for the authorization request. It is worth noting that OC has 1,601 members across 8 HNs, which means 1 non-compliant file will decrease compliance below the threshold of 98%.

OneCare 2020 HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=8)	Issues Identified
Routine TAT Timeliness	67.14–99.78%	4	Failure to provide timely provider notification
Urgent TAT Timeliness	10.37–97.5%	0	Failure to provide timely provider notification
Clinical Decision Making	84–100%	5	Use of lay language to identify why request did not meet criteria, failure to cite criteria for decision and failure to use CMS notification template.
Notifications	67–100%	5	Failure to describe why request did not meet lay language

CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by 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.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal Shared Risk

- **Average Length of Stay (ALOS):** For Seniors and Persons with Disabilities (SPD) and Temporary Assistance for Needy Families (TANF) >18 aid code categories, ALOS trended downward for the final quarter in 2019 and the first quarter of 2020, and subsequently trended upward through the third quarter of 2020. The ALOS trend for members in TANF ≤ 18 aid code category shows a downward trend for the final quarter of 2019 through the second quarter in 2020 with a slight uptick in the third quarter 2020.
- **Bed Days/Per Thousand Members Per Year (PTMPY):** SPD and TANF >18 subpopulations consistently met the 2020 goal, with only a slight increase in Q3 2020 for the SPD group. The TANF ≤18 exceeded the goal for every quarter except Q2 2020.
- **Readmissions:** Readmissions were stable for the SPD and TANF >18 subpopulations at approximately 23% and 17% respectively. TANF ≤18 ended 2019 at 12% and decreased to 8% for the first three quarters of 2020.
- **ED Visits/PTMPY:**
    - **SPD:** Goal was met for all four quarters of the reporting data.
    - **TANF ≤ 18:** Goal was met for all quarters except Q1 2020 with a .69% increase above

goal threshold.

- **TANF > 18:** Goal was not met in Q4 2019 and Q1 2020 but fell within desired threshold for Q2 and Q3 2020.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

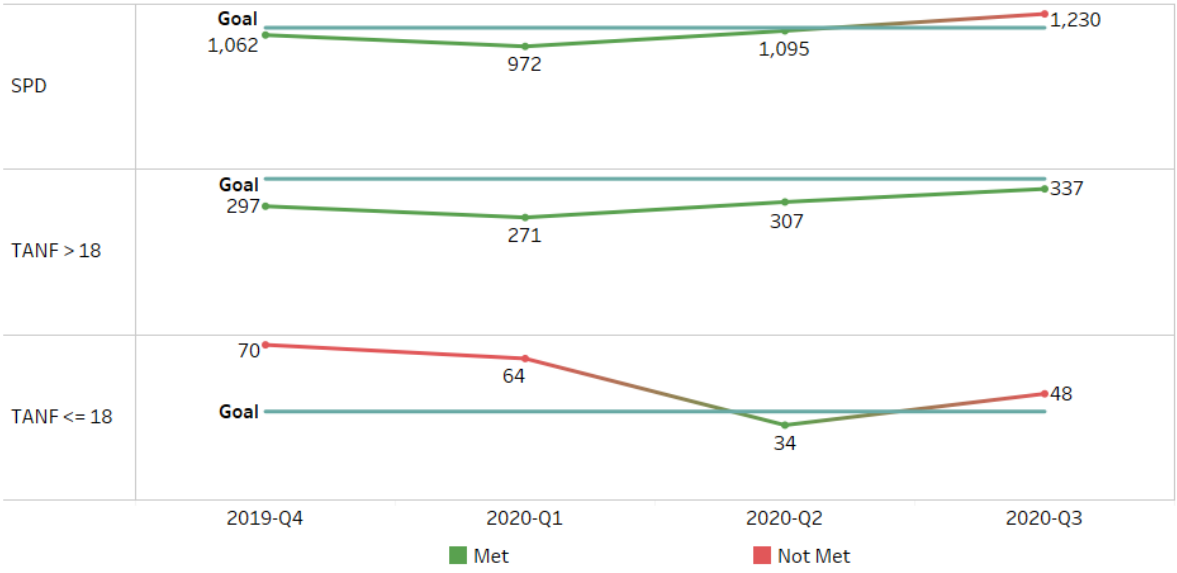
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.5	5.0	7.1	7.2
	Bed Days PTMPY	1,062	972	1,095	1,230
	Pcnt Re-Admits	22%	22%	23%	23%
	ED Visits PTMPY	625	603	419	500
TANF > 18	ALOS	4.4	4.3	5.7	5.6
	Bed Days PTMPY	297	271	307	337
	Pcnt Re-Admits	18%	17%	17%	17%
	ED Visits PTMPY	416	434	304	342
TANF <= 18	ALOS	4.0	3.5	3.3	4.6
	Bed Days PTMPY	70	64	34	48
	Pcnt Re-Admits	12%	8%	8%	8%
	ED Visits PTMPY	349	377	109	146

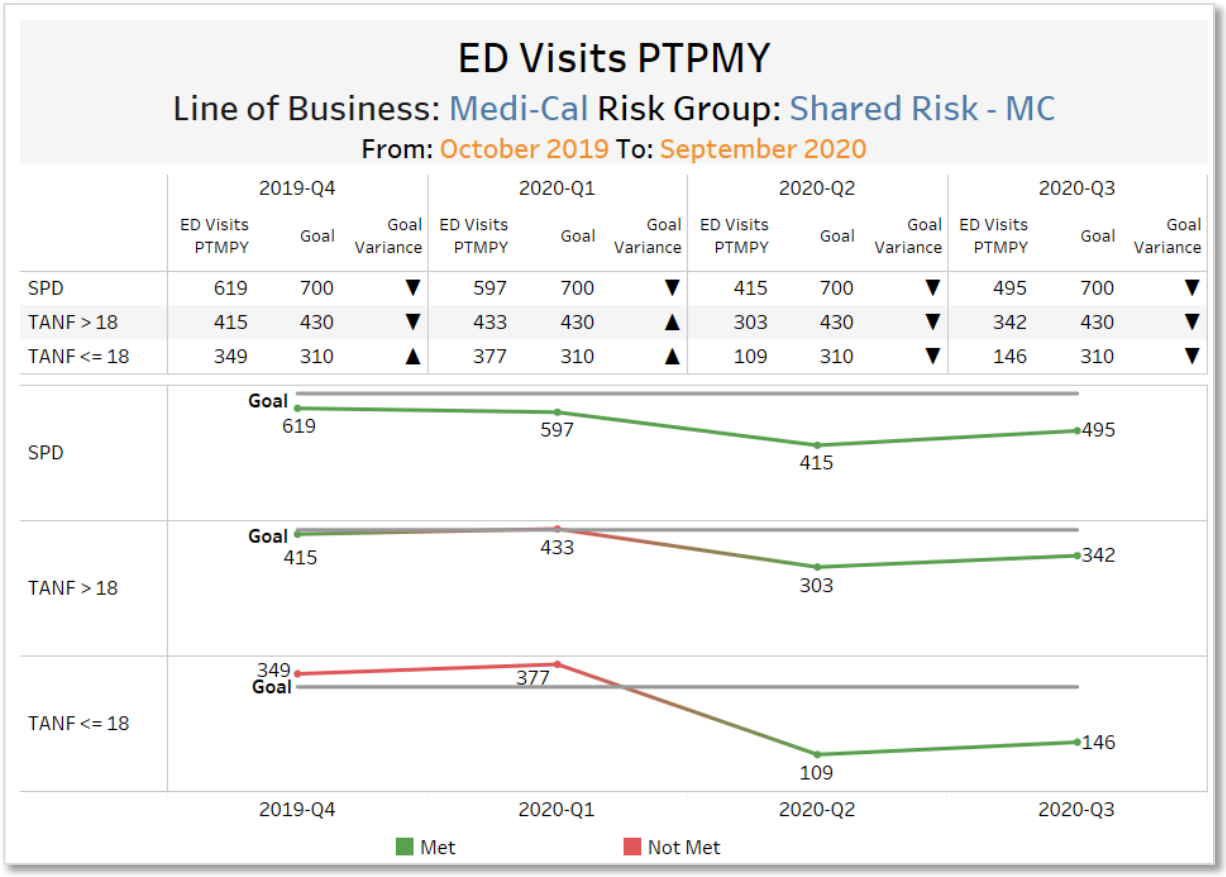
Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,062	1,120	▼	972	1,120	▼	1,095	1,120	▼	1,230	1,120	▲
TANF > 18	297	360	▼	271	360	▼	307	360	▼	337	360	▼
TANF <= 18	70	40	▲	64	40	▲	34	40	▼	48	40	▲





Medi-Cal CCN

- **Average Length of Stay**
  - **SPD and TANF > 18:** Stable for Q4 2019 and Q1 2020, increases for Q2 and Q3 2020.
  - **TANF ≤ 18:** Trended upward for the first three quarters of the reporting period and dips slightly in Q3 2020.
- **Bed Days/PTMPY:** SPD bed days were consistently above the goal threshold for all four quarters by an average of approximately 7.4%. TANF subpopulations consistently met the goal for all four quarters.
- **Readmissions:** SPD readmissions increased for the first three quarters of the reporting period and decreased by 5 percentage points in Q3 2020. TANF >18 readmissions were mildly volatile during this period, decreasing in Q4 2019 and Q2 2020, increasing in Q1 and Q3 2020. TANF ≤ 18 increased from Q4 2019 through Q2 2020 and dropped by 15 percentage points in Q3 2020.
- **ED Visits/PTMPY**
  - **SPD:** Goal was not met in Q4 2019 and Q1 2020, met goal for remaining quarters.
  - **TANF > 18:** Goal was not met in Q4 2019 and Q1 2020, met goal for remaining quarters.
  - **TANF ≤ 18:** Goal was met for all four quarters.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

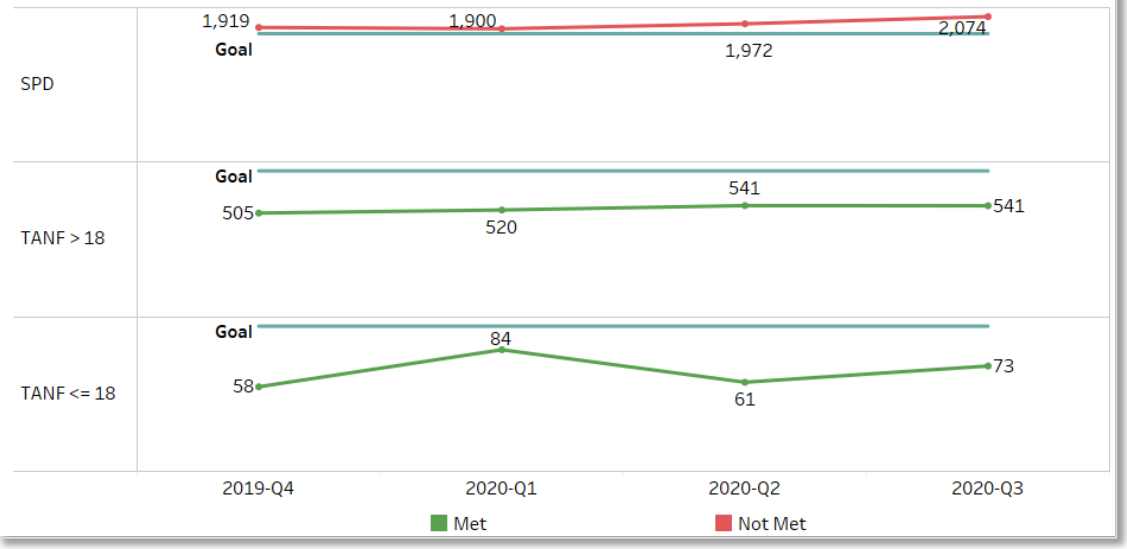
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.6	5.8	7.7	7.2
	Bed Days PTMPY	1,919	1,900	1,972	2,074
	Pcnt Re-Admits	31%	34%	35%	30%
	ED Visits PTMPY	827	874	484	582
TANF > 18	ALOS	5.5	5.5	6.6	6.5
	Bed Days PTMPY	505	520	541	541
	Pcnt Re-Admits	26%	28%	25%	30%
	ED Visits PTMPY	589	582	382	448
TANF <= 18	ALOS	3.3	4.4	5.6	5.5
	Bed Days PTMPY	58	84	61	73
	Pcnt Re-Admits	9%	13%	21%	6%
	ED Visits PTMPY	444	453	131	183

Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,919	1,830	▲	1,900	1,830	▲	1,972	1,830	▲	2,074	1,830	▲
TANF > 18	505	710	▼	520	710	▼	541	710	▼	541	710	▼
TANF <= 18	58	100	▼	84	100	▼	61	100	▼	73	100	▼



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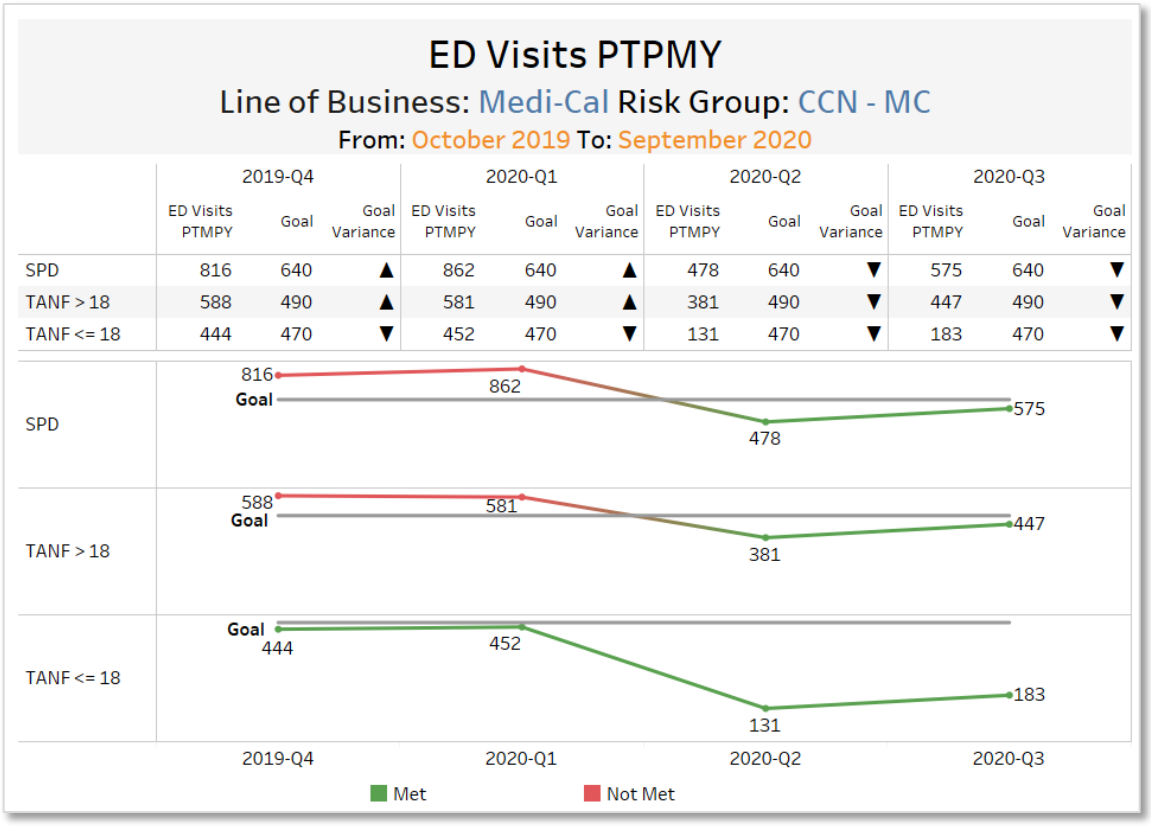


CalOptima Direct Administrative (CODA)

- **Average Length of Stay:**
  - **SPD:** Consistently increases through Q4 2019 and Q2 2020, dips slightly in Q3.
  - **TANF >18/ TANF≤18:** Increases consistently over the four quarters reported.
- **Bed Days/PTMPY:** Both SPD and TANF >18 was consistently within the goal; however, SPD did not meet the goal for Q3 2020. TANF ≤18 did not meet the goal for all four quarters reported.
- **Readmissions:** SPD and TANF ≤18 increase slightly between Q4 2019 and Q1 2020 and subsequently decrease sharply through Q3 2020. TANF >18 remained a little more stable, hovering between 10 and 18%.
- **ED Visits/PTMPY:** No SPD data for ED visits, both TANF subpopulations met the goal for all four quarters.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

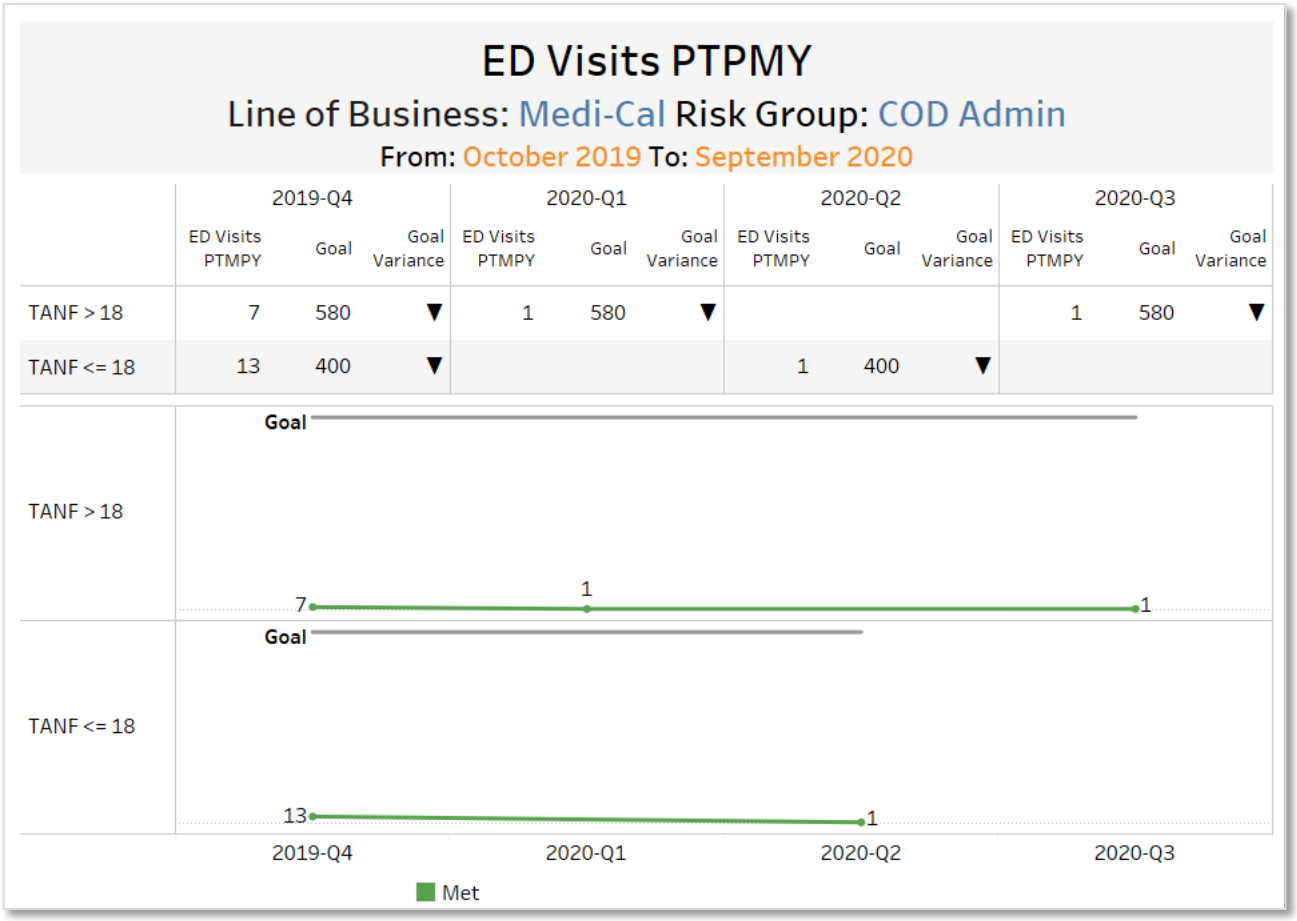
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	6.2	7.4	10.7	9.5
	Bed Days PTMPY	1,528	1,910	1,691	2,430
	Pcnt Re-Admits	23%	26%	14%	4%
	ED Visits PTMPY				
TANF > 18	ALOS	5.0	5.8	6.1	7.6
	Bed Days PTMPY	390	315	340	460
	Pcnt Re-Admits	17%	13%	18%	10%
	ED Visits PTMPY	7	1		1
TANF <= 18	ALOS	8.8	9.5	12.5	12.4
	Bed Days PTMPY	441	505	503	574
	Pcnt Re-Admits	6%	8%	3%	0%
	ED Visits PTMPY	13		1	

Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,528	1,920	▼	1,910	1,920	▼	1,691	1,920	▼	2,430	1,920	▲
TANF > 18	390	600	▼	315	600	▼	340	600	▼	460	600	▼
TANF <= 18	441	75	▲	505	75	▲	503	75	▲	574	75	▲



OneCare Connect Shared Risk

- **Average Length of Stay:**
  - **SPD:** Consistent from Q4 2019 through Q1 2020, rose slightly in Q2 and Q3 2020.
  - **TANF >18:** Fluctuated between Q4 2019 and Q2 2020 by about 1.1 average days.
- **Bed Days/PTMPY:** SPD group did not meet the goal in Q4 2019 and Q3 2020 but met the goal for the remaining quarters. There is not established goal for the TANF >18 group, however we do see a sharp increase in volume of 457% between Q4 2019 and Q1 2020 and then a 48% decrease in Q3 2020.
- **Readmissions:** SPD readmissions decrease by about 1% quarter-over-quarter. The TANF group increases by 9% in Q1 2020 and then sharply by 42% in Q2 2020.
- **ED Visits/PTMPY:** SPD ED visits consistently met the goal for all four quarters. The TANF >18 group does not have an established goal but remained consistent for all four quarters.

NOTE: For Q3 2020 there are not any data for TANF >18 at this time, most likely due to immaturity of the data.

Utilization Outcomes

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

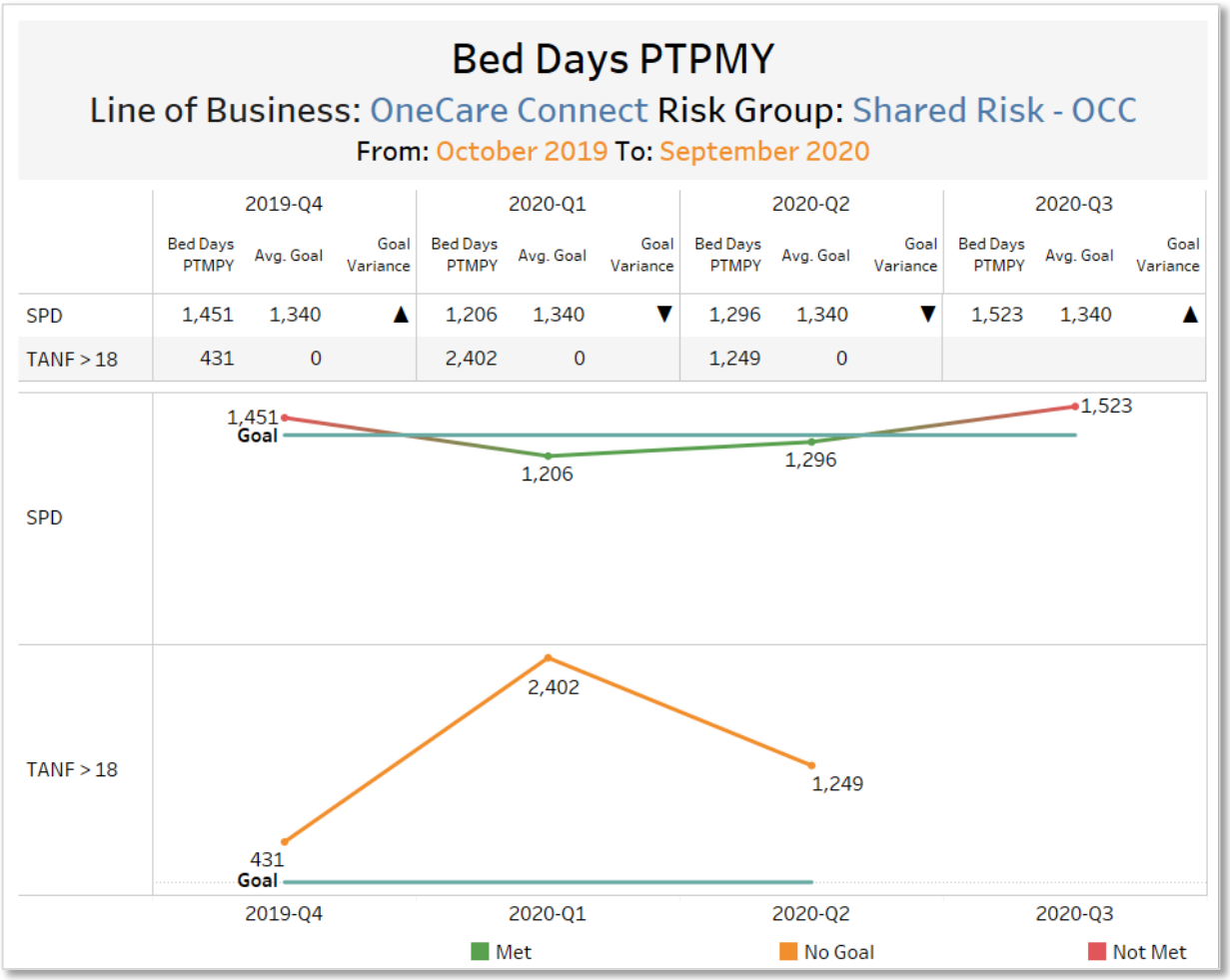
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.9	5.9	7.3	7.1
	Bed Days PTMPY	1,451	1,206	1,296	1,523
	Pcnt Re-Admits	24%	23%	22%	20%
	ED Visits PTMPY	370	363	240	262
TANF > 18	ALOS	4.5	6.0	5.3	
	Bed Days PTMPY	431	2,402	1,249	
	Pcnt Re-Admits	50%	50%	100%	
	ED Visits PTMPY	334	478	403	

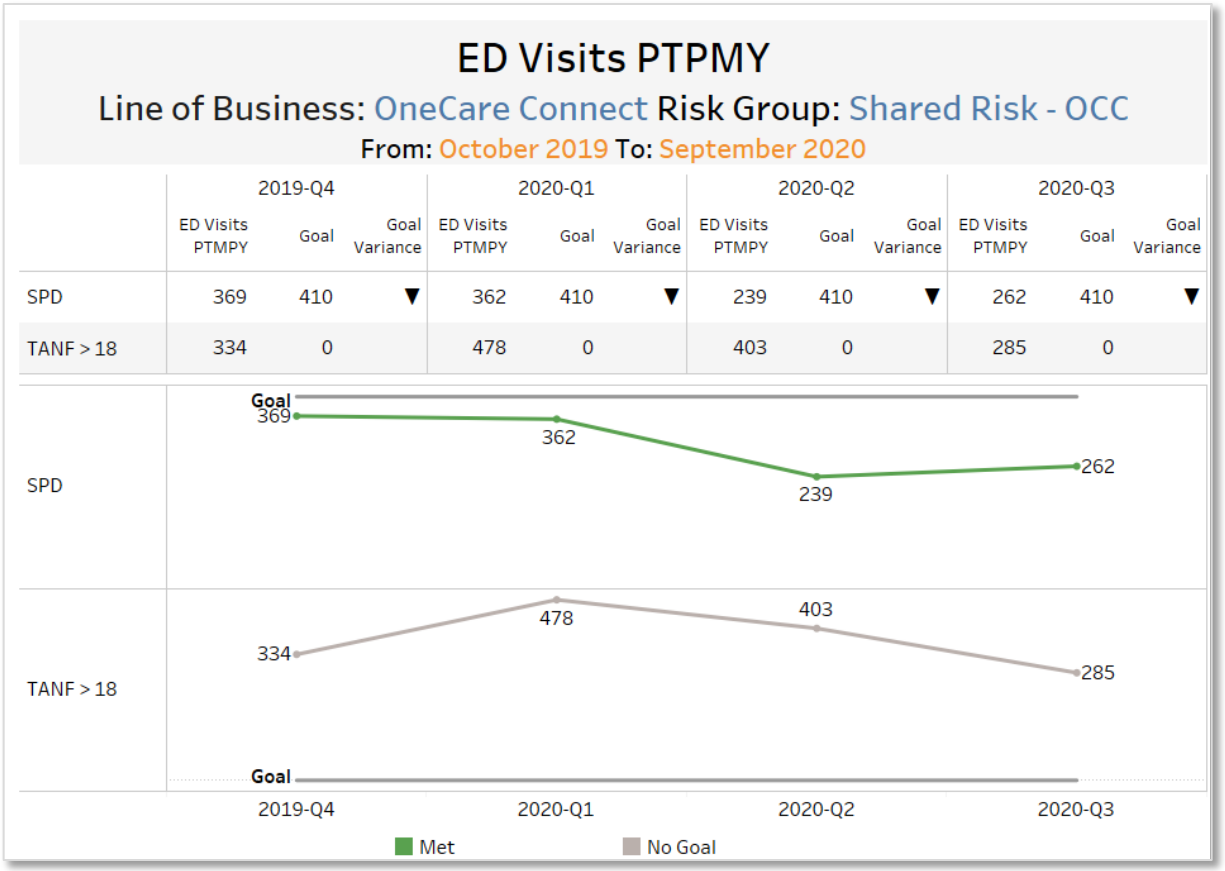
Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,451	1,340	▲	1,206	1,340	▼	1,296	1,340	▼	1,523	1,340	▲
TANF > 18	431	0		2,402	0		1,249	0				





OneCare Connect CCN

- **Average Length of Stay:** SPD population increased during each of the first 3 quarters of the reporting period, with a decrease in Q3 2020. The TANF >18 population was mildly volatile during the reporting period, spiking in Q1 2020.
- **Bed Days/PTPMY:** The SPD group met the goal for all four quarters. There is no established goal for the TANF >18 group, however, we do see volatility and a sharp increase of 309% in Q1 2020.
- **Readmissions:** SPD population remained stable during all four quarters, hovering between 27 and 33%. The TANF >18 group readmissions only occurred in Q1 2020 at 17%.
- **ED Visits/PTPMY:** SPD did not meet the goal for all four quarters. The TANF >18 population has no established goal but trended downward during the reporting period with a slight increase in Q3 2020.

Utilization Outcomes

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2019 To: September 2020

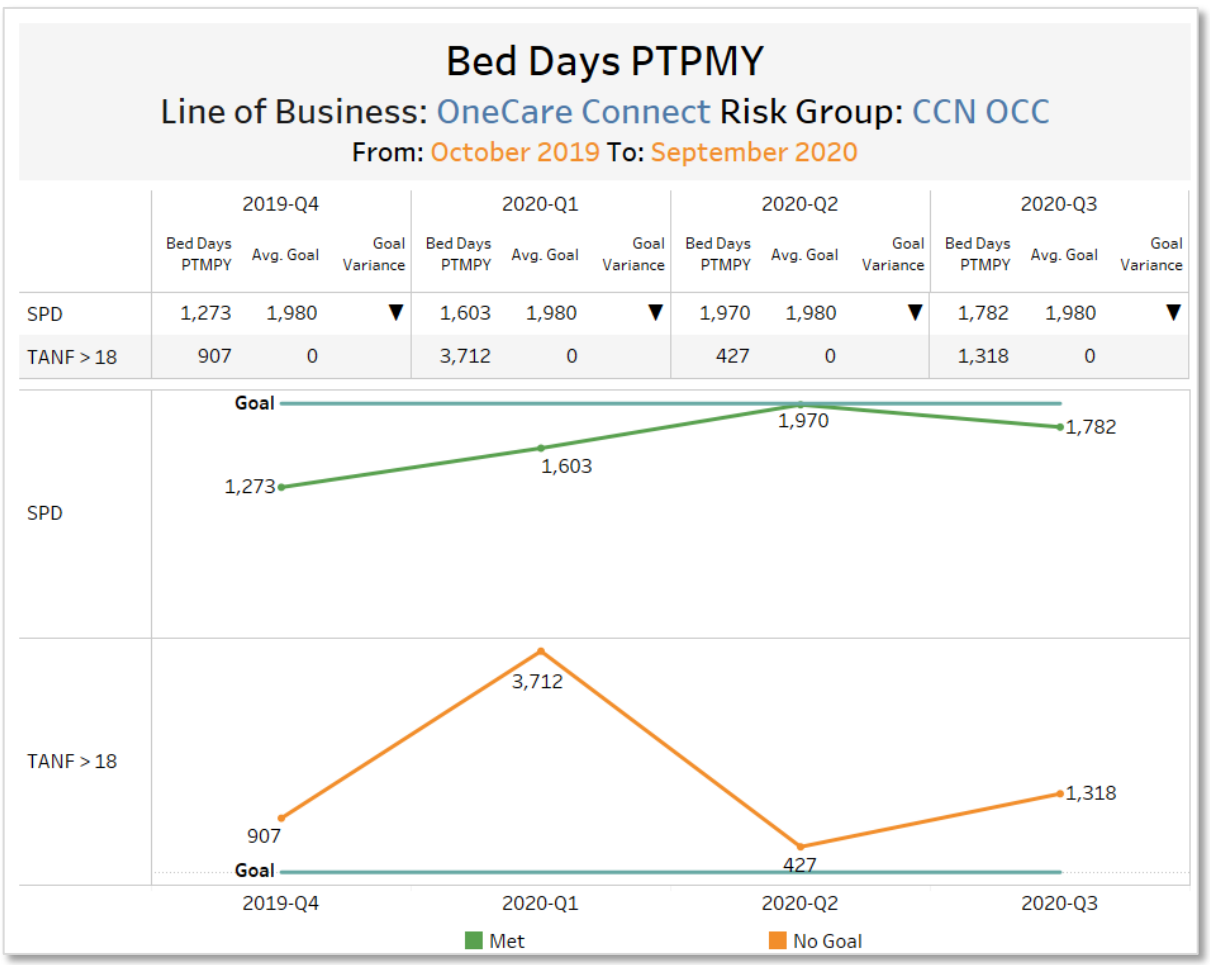
			2019-Q4	2020-Q1	2020-Q2	2020-Q3
CCN OCC	SPD	ALOS	4.8	6.0	8.2	7.2
		Bed Days PTMPY	1,273	1,603	1,970	1,782
		Pcnt Re-Admits	28%	28%	27%	33%
		ED Visits PTMPY	660	579	492	449
	TANF > 18	ALOS	2.7	8.0	1.7	3.5
		Bed Days PTMPY	907	3,712	427	1,318
		Pcnt Re-Admits	0%	17%	0%	0%
		ED Visits PTMPY	2,776	1,241	240	423

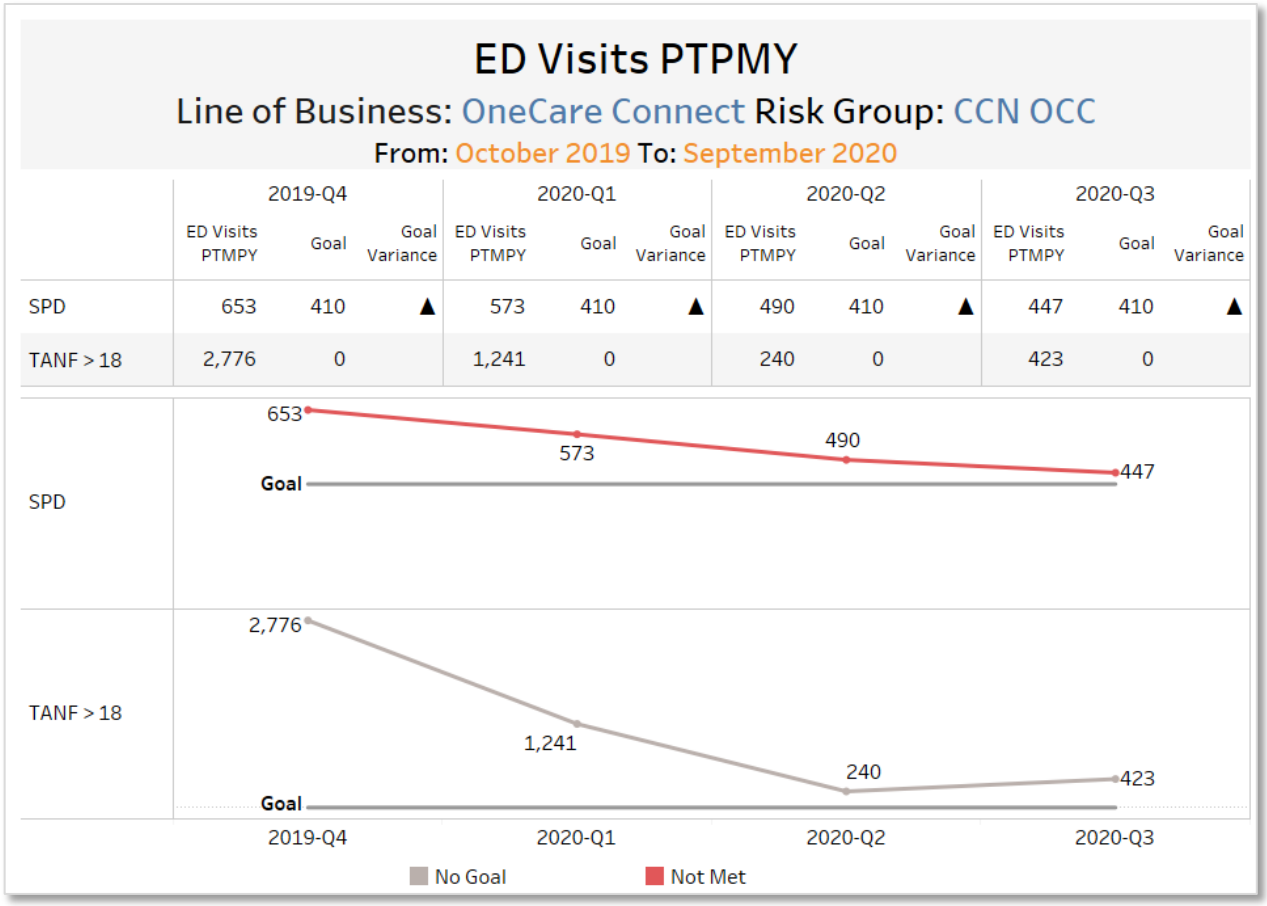
Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2019 To: September 2020

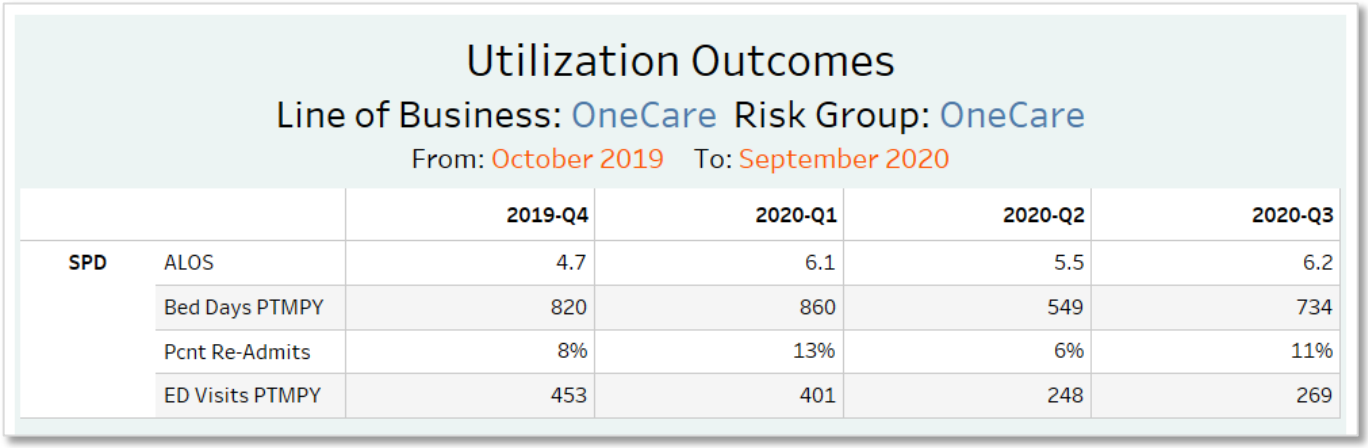
	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,273	1,980	▼	1,603	1,980	▼	1,970	1,980	▼	1,782	1,980	▼
TANF > 18	907	0		3,712	0		427	0		1,318	0	





OneCare

- **Average Length of Stay:** The SPD population slightly increases between Q4 2019 and Q1 2020 and between Q2 2020 and Q3 2020.
- **Bed Days/PTPMY:** The SPD population consistently met the goal for all four quarters.
- **Readmissions:** The SPD population increased slightly in Q1 2020 and Q3 2020.
- **ED Visits/PTPMY:** The SPD population consistently met the goal for all four quarters.



Utilization Outcomes

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

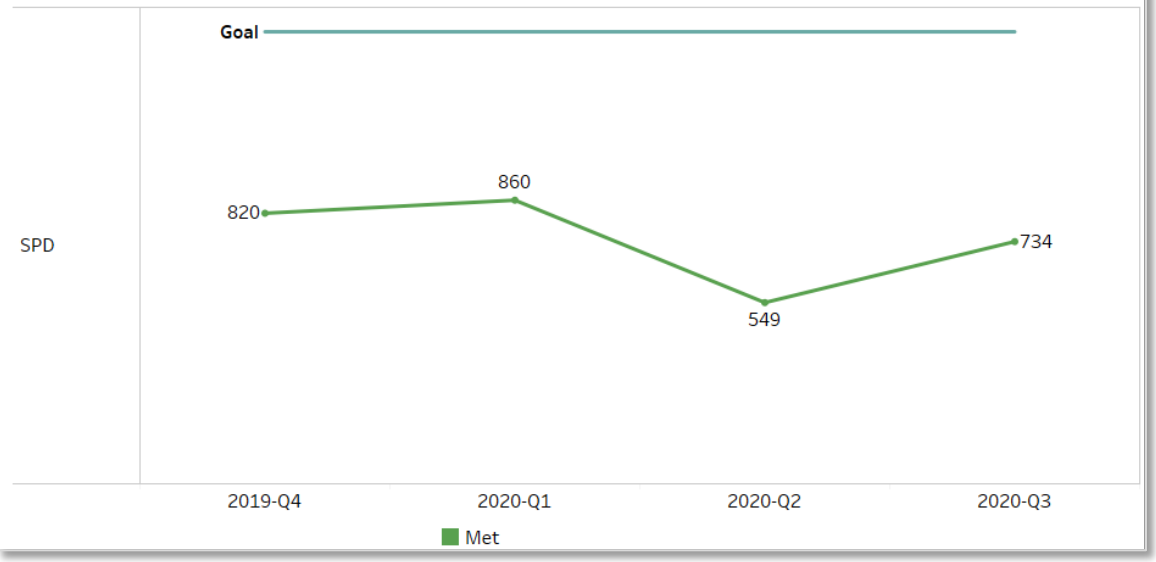
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	4.7	6.1	5.5	6.2
	Bed Days PTMPY	820	860	549	734
	Pcnt Re-Admits	8%	13%	6%	11%
	ED Visits PTMPY	453	401	248	269

Bed Days PTPMY

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	820	1,370	▼	860	1,370	▼	549	1,370	▼	734	1,370	▼

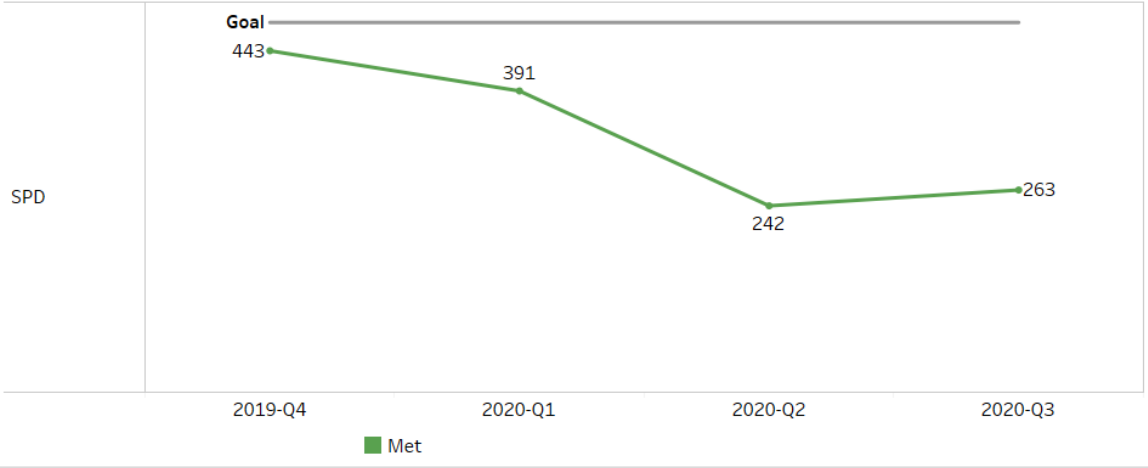


ED Visits PTPMY

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
SPD	443	480	▼	391	480	▼	242	480	▼	263	480	▼



Over and Underutilization

In 2020 the process for monitoring of over and underutilization was enhanced as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization and the development of a cross departmental dashboard, maintained by UM. Metrics were identified throughout the organization as good indicators of over and underutilization, as well as drill down into the metrics to ensure proper identification of over and underutilization. Metrics from the following area are included and will be reviewed on an annual basis to ensure they are indicative of over and underutilization monitoring. The metrics include inpatient and prior authorization UM measure, appeal volumes and overturn rate, member grievances, adult and children's access to PCP services, measures indicative of appropriate utilization for pharmaceuticals, outlier reporting from the fraud, waste and abuse department within CalOptima, referral pattern analyses, member utilization, UM related member complaints, potential quality issues (PQI) monitoring, and measures related to behavioral health care.

Over and underutilization was monitored, tracked, managed, and reported by UM during 2020 and reported to UMC, QIC and the Quality Assurance Committee (QAC). Through quarter 3 of 2020, we identified one area of overutilization related pre-natal ultrasounds being ordered by one physician multiple times, when the recommendation is one ultrasound within 180 days and any others within that period will require prior authorization. Provider education has occurred via a memo and by provider relation outreach.

III. Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests — Medical

2020 — Summary of referral volume (Q4 2019 to Q3 2020)

Referrals Processed		Referrals Received		Turnaround Time Compliance (TAT)	
Routine	**138,240**	Faxed	**80,324**	Routine TAT	**99.22%**
Urgent	**16,918**	COLAS	**100,177**	Urgent TAT	**99.15%**
Retro	**9,356**	Auto Auth	**25,279**	Retro TAT	**99.83%**
Total	**155,158***	**Total**	**180,501**		

- Total volume of referrals shows a year-over-year increase 8,607 (5.9%) based on data from Q1–3 2019 compared to Q4 2019 through Q3 2020.
- Volume of faxed referrals decreased from Q1–3 2019 by 9,800 or 10.9%
- Volume of portal (COLA) referrals decreased from 2019 report by 365 or .36%

It is also worth noting that we have indicated the volume of referrals that were automatically authorized when submitted via our portal, as in April we implemented an auto authorization process for initial consults for 9 specialties, chosen based on analysis of data and meeting an approval rate of 99% or greater.

* The difference between referrals received and processed may be attributed to duplicate

submissions and/or requests that do not require authorization.

Online Referral Rate Submission

Online referral submission increased over the 3 quarters by 11% in 2020. In 2019, Q1–Q3, there were 91,334 online referrals and during the same period of 2020, there were 100,177.

- Referral TAT was compliant for all referral types in the first 3 quarters of 2020.

B. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance through Q3 2020:

LOB	TAT Compliance
Medi-Cal	98.1 %
OC	100%
OCC	99.4%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets were achieved for 2020.

C. Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for Q4 2020–Q3 2020:
  - CBAS CEDT: 100%
  - CBAS Routine: 100%
  - CBAS Expedited: None received
    - Members participating in CBAS Q4 2019 & Q1–Q3 2020: Potentially program-eligible members.

Year	Qtr.	LOB	Members Participating in CBAS Q4 2019-Q3 2020 / Potentially Program-Eligible Members	% Participating	Change from Previous Qtr.
2019	Q4	Medi-Cal	2,590 / 116,463	2.22%	↑
		OCC	195 / 14,160	1.38%	↑
2020	Q1	Medi-Cal	2,565 / 114,555	2.24%	↑
		OCC	194 / 14,191	1.37%	↑
	Q2	Medi-Cal	2,245 / 105,321	2.13%	↓
		OCC	170 / 14,408	1.18%	↓

	Q3	Medi-Cal	2,384 / 120,253	1.98%	↓
		OCC	164 / 14,711	1.11%	↓

- 80% of authorized CBAS participation days will be utilized/delivered (Q4 2019) to Q3 2020.

Year	Qtr.	CBAS Participation Days Used / Days Authorized	% Used	Change from Previous Qtr.
2019	Q4	98,616 / 133,320	73.97%	↓
2020	Q1	89,668 / 129,236	69.38%	↓
	Q2	105,758 / 129,144	81.89%	↑
	Q3	107,255 / 122,417	87.61%	↑

  - o LTC Routine: 98.99%
  - o LTC Urgent: None received
  - o MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

Year	Qtr.	Admissions/ Discharges	Change from Previous Qtr.
2019	Q4	34 / 34	No Change
2020	Q1	31 / 28	Admissions ↑
	Q2	24 / 14	Admissions ↓
	Q3	19 / 20	Admissions ↓

- MSSP Goal met. Continue with this goal.

D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2020. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

2020 CalOptima Utilization Management Program Evaluation

Department	IRR Score
UM Clinical Staff: Prior Authorization	90%
UM Clinical Staff: Concurrent Review	90%
Physicians	97%
Pharmacy	100%
LTSS: LTC	100%
LTSS: CBAS	100%
LTSS: MSSP	Did not test in 2020

E. Denial (Letter) Process

Performance has continued to improve throughout 2020. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the HNs. A workgroup begun in 2020 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA 2020 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

IV. Utilization Performance / Outcomes

A. Facility Utilization — Facility Acute and Emergency Care

Analysis of inpatient and ED data in 2020 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of 2020 ED Data will be conducted, and additional interventions may be applied as needed. LTC Nursing facility members transitioned to the Community:

Year	Qtr.	LOB	LTC Nursing Facility Members Transition to the Community	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	182 / 5,133	3.55%	↑
		OCC	6 / 205	2.93%	↑
2020	Q1	Medi-Cal	163 / 5,181	3.15%	↓
		OCC	6 / 201	2.99%	↑
	Q2	Medi-Cal	148 / 5,192	2.85%	↓
		OCC	7 / 185	3.78%	↑

	Q3	Medi-Cal	158 / 4,738	3.33%	↑
		OCC	4 / 161	2.48%	↓

CBAS: Track CBAS participants who transition to LTC.

Yr.	Qtr.	LOB	CBAS participants who transition to LTC	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	8 / 2,590	0.31%	↑
		OCC	1 / 195	0.51%	↓
2020	Q1	Medi-Cal	10 / 2,565	0.39%	↑
		OCC	1 / 194	0.52%	↑
	Q2	Medi-Cal	4 / 2,345	0.17%	↓
		OCC	0 / 170	0.00%	↓
	Q3	Medi-Cal	7 / 2,384	0.29%	↑
		OCC	0 / 164	0.00%	←

LTC: Members residing in LTC: Potentially nursing home eligible members.

Year	Qtr.	LOB	Members Residing in LTC/ Potentially Nursing Home Eligible Members	% Residing in LTC	Change from Previous Qtr.
2019	Q4	Medi-Cal	5,133 / 116,443	4.41%	↓
		OCC	205 / 14,168	1.45%	↓
2020	Q1	Medi-Cal	5,181 / 114,555	4.52%	↑
		OCC	201 / 14,191	1.42%	↓
	Q2	Medi-Cal	5,192 / 105,321	4.93%	↑
		OCC	105 / 14,408	0.73%	↓
	Q3	Medi-Cal	4,738 / 120,253	3.94%	↓
		OCC	161 / 14,711	1.09%	↑

B. Pharmacy Utilization

- Retail Pharmacy: $PMPM costs from 4Q19 to 3Q20 are below goal for OneCare and

Medi-Cal, and above goal for OneCare Connect. Medi-Cal pharmacy costs increased 7% after the start of the Whole Child Model (WCM) on July 1, 2019. OneCare Connect drug cost increases are primarily driven by increased utilization of diabetes medications as well as drug price increases for a large number of branded medications.

LOB	Goal $PMPM	Actual $PMPM (Q4 2019–Q3 2020)
Medi-Cal	$71.57	$71.11
OC	$370.76	$370.10
OCC	$420.44	$433.98

- Opioid analgesic utilization (average morphine milligram equivalent) has decreased 11.2% from 4Q19 to 3Q20.

C. Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters.
  - New member orientation is available for all CalOptima members to better understand their benefits.
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website.
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed.
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members.
  - A Provider Toolkit is available on the CalOptima website for provider reference.
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers.
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In 2020, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making.
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed.
  - Overall improvement in audit scores for clinical decision making in 2020.

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2020, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
  - Access to providers, specifically providers no longer contracted with CalOptima.
  - Provider not seeing new patients.
  - Provider was unable to see the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Limitation of members ability to see certain providers, as there are some providers who only see members already affiliated with their organization.

- Provider concerns:
    - Most complaints from providers were related to changes in our portal to safeguard PHI and inability for them to self-serve to obtain information about their referral.

CalOptima is continually looking at improving access to providers, including alternative types of visits, such as telehealth. All member issues were resolved by either redirecting the members care to another specialist that is able to meet the member's needs. We are looking at ways to improve provider data in our systems, including finding a new product to use for provider data management that interfaces with multiple systems. Provider relations has also worked very diligently to ensure the provider data is accurate, by confirming information accuracy with providers.

Access to authorization data has been mitigated by adding safeguards within the portal to verify the provider has a relationship with the member and displaying the members phone number only on authorization notices to limit PHI exposure and ensure the provider is able to reach out to the member to deliver necessary care.

V. SUMMARY

In 2020, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers through the implementation of auto authorizations for select specialties. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance, maintenance of current policies and procedures, report development.

The UMC and the UM Medical Director and Behavioral Health Medical Director continue to guide and support CalOptima UM programs, both medical and behavioral. The UMC met six times in 2020, with two of the meeting being virtual. Pharmacy and Therapeutics Committee (P&T) and the BMSC reported quarterly to the UMC in 2020. Quarterly UM operational performance and health care utilization data and over and underutilization analysis and trends are presented, reviewed, and discussed at the UMC and guide future efforts of the CalOptima UM Program.

20210 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

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~~2019~~ 2021 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

~~Paul Yost~~Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

~~Paul Yost~~Andrew Do~~, M.D.~~ **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members ~~is~~ was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

Our Values——CalOptima CARES

Collaboration:

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability:

We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect:

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence:

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members'

health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship:
We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures**,** including providing opportunities for stakeholder input.
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal
In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services
Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (~~OC~~ HCA).
- Substance use disorder services are administered by ~~OC~~ HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs
To ensure that clinical services as described above are accessible and available to members with special health care needs—such as seniors, people with disabilities and people with chronic conditions—CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including ~~Orange County Health Care Agency (OC~~ HCA~~)~~ and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare ~~-~~(HMO SNP)

Our OneCare (OC~~HMO SNP~~) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OneCare (OC) to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled,

dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral, and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits, such as vision care, gym benefits, over-the-counter medication benefits, and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail ~~elders~~ seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)

COVID-19 PHE created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 PHE, the Health Equity strategy, as well as the COVID-19 PHE Vaccination and Communication strategy. Additionally, UM requirements for COVID PHE screening, vaccinates and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 PHE shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 PHE analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 PHE adversely impacted the mental health of many members, especially children. ~~Hence~~Therefore, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 PHE.

~~:-The-itsW P-the- of many members, especially children, several trauma-~~

~~informed interventions are included in the 2021 QI Work Plan to address the toxic stress and (ACEs) related to the COVID-19 pandemic.~~

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the ~~OC~~ HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. ~~The WPC~~The WPC information sharing platform was launched in November 2018. ~~For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.~~WPC is scheduled to terminate December 31, 2020~~,~~; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicare Services (CMS) extend the pilot for an additional year

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance.

As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned~~s~~ to CalOptima in 2019 and will continue ~~indefinately~~indefinitely**.** Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with ~~OC~~ HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima ~~planned to~~ implemented HHP in ~~the following~~ two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD)~~;~~ and July 1, 2020, for members with serious mental illness (SMI) or ~~S~~serious ~~E~~emotional ~~D~~disturbance (SED~~MI~~). During implementation, HHP

~~CalOptima's goal is to~~ targeted the highest-risk 3–5 ~~percent~~ % of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME)

will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC, who are also eligible for the HHP, to continue with their current WPC providers for their housing related services. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

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

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the Ccounty. Homeless health initiatives supported by CalOptima include:

- Recuperative Care——As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with Whole-Person Care program, and the CalOptima Board of Director's has authorizationed tothe extendsion of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.
- Medical Respite Care——As an extension to the recuperative care program, CalOptima provideds a grant to HCA to additionalprovide additional respite care beyond the 90 days of recuperative care under the Whole Person Care program. These grant funds have been exhausted.
- Clinical Field Teams——In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency'sHCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19, these services are available via telehealth, in addition to in person.

——Homeless Clinical Access Program——Thise Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through

mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. CalOptima provides preventive screenings, chronic care, care coordination and follow up.

-
- Hospital Discharge Process for Members Experiencing Homelessness——Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

It is expected that, e~~E~~ffective April 1, 2021, the Department of Health Care Service (DHCS) ~~is~~will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/ prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect the OneCare~~/~~ or OneCare Connect lines of business.

Virtual Care Strategy

In 2021, federal and state rules and regulations provided limited waivers for telehealth due to the ~~COVID-19~~COVID-19 PHE ~~pandemic~~, that enabled CalOptima to accelerate its virtual care strategy under ~~COVID-19~~COVID-19 PHE shelter-at-home measures. Members were able to receive appropriate health care services through telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.
2. Leverage existing delivery model where possible.
3. Be proactive in seeking out opportunities to innovate.
4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work ~~p~~Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

- ——CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.~~The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.~~

~~**Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under new state requirements.**~~

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping m~~M~~embers h~~H~~ealthy
2. Managing m~~M~~embers with c~~E~~merging r~~R~~isks
3. Patient s~~S~~afety or o~~O~~utcomes a~~A~~cross s~~S~~ettings
4. Managing m~~M~~ultiple c~~C~~hronic c~~C~~onditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

~~CalOptima has developed a comprehensive PHM Strategy, which includes actions to address the needs of our culturally diverse members across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards.. CalOptima's PHM Strategy aims to ensure that 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.~~

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical

services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs.– Quality Initiatives for 20210 are tracked in the QI Work ~~p~~Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing ~~the~~ evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation, and care delivery system to improve member - focused trauma informed care to be consistent with NCQA ~~2020~~ Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-~~-~~Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

~~**CalOptima's PHM Strategy is based on numerous efforts to assess the health and well-being of**~~

~~**our members, such as the Member Health Needs Assessment. It focused on ethnic and linguistic minorities within the Medi-Cal**~~

~~POPULATION FROM BIRTH TO AGE 101.~~

~~THE PHM STRATEGY ADDRESSES THE UNIQUE NEEDS AND CHALLENGES OF SPECIFIC ETHNIC COMMUNITIES INCLUDING ECONOMIC, SOCIAL, SPIRITUAL, AND ENVIRONMENTAL STRESSORS, TO IMPROVE HEALTH OUTCOMES.~~

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs ~~-~~providing health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-~~Administration~~ Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs, representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligible~~'~~s (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. ~~Members enrolled in CalOptima Direct-Administrative are not HN eligible.~~

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered ~~internally~~ directly by CalOptima and available for HN eligible members to select, supplementing the HN delivery model and creating additional capacity for ~~growth~~access.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

~~Health Network/Delegate~~	~~Medi-Cal~~	~~OneCare~~	~~OneCare Connect~~
~~AltaMed Health Services~~	~~SRG~~	~~SRG~~	~~SRG~~
~~AMVI/Prospect~~		~~SRG~~	
~~AMVI Care Health Network~~	~~PHC~~		~~PHC~~
~~Arta Western Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
~~CHOC Health Alliance~~	~~PHC~~		
~~Family Choice Health Network~~	~~PHC~~	~~SRG~~	~~SRG~~
~~Heritage~~	~~HMO~~		~~HMO~~
~~Kaiser Permanente~~	~~HMO~~		
~~Monarch Family HealthCare~~	~~HMO~~	~~SRG~~	~~HMO~~

~~Health Network/Delegate~~	~~Medi-Cal~~	~~OneCare~~	~~OneCare Connect~~
~~Noble Mid-Orange County~~	~~SRG~~	~~SRG~~	~~SRG~~
~~Prospect Medical Group~~	~~HMO~~		~~HMO~~
~~Talbert Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
~~United Care Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer s~~S~~ervices activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2020

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

Membership Data as of November 30, 2019

Total CalOptima Membership
755,539

Program	Members
Medi-Cal*	739,601
OneCare Connect	14,065
OneCare (HMO SNP)	1,498
Program of All-Inclusive Care for the Elderly (PACE)	375

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2021

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

Membership Data from November 30, 2020 Financial Information

Total CalOptima Membership
801,270

Program	Members
Medi-Cal*	784,665
OneCare Connect	14,587
OneCare (HMO SNP)	1,625
Program of All-Inclusive Care for the Elderly (PACE)	393

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior period adjustments

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
33%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for -review of health care services, treatment, and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, and home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA ~~S~~standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on Medical Necessity and/or benefit coverage.
- Identify and refer high-risk members to Case Management ~~P~~programs, including Complex Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate practitioners and other providers, including delegated HNs on CalOptima's UM Program, policies and procedures on an ongoing basis.
- Monitor utilization practice patterns of practitioners to identify variations from the standard

practice that may indicate need for additional education or support.

- Continuous identification of UM staff needs, and appropriate training delivered to address those needs, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality--based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.
The organization chart and the UM Program~~'s committees reporting structure~~ reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization ~~m~~Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee~~'~~s' charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the delegate's UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs' UM activities by the Audit and Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to

determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

LONG-TERM SUPPORT SERVICES ~~AND SUPPORTS~~

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- ~~Starting i~~In April 2020, all LTC ~~M~~member facility clinical reviews and medical necessity nursing facility visits were suspended due to the ~~COVID-19~~COVID-19 PHE health emergency. ~~-~~ All clinical review is now ~~being~~ performed electronically and telephonically.

Home~~-~~and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). ~~Starting i~~In April 2020 all CBAS ~~M~~member and facility clinical reviews and medical necessity visits were suspended due to the ~~COVID-19~~COVID-19 PHE- health emergency. -All clinical and medical necessity review is now ~~being~~ performed electronically and telephonically.
- MSSP: Home~~-~~and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020 all MSSP ~~M~~member and facility clinical reviews and medical necessity visits were suspended due to the ~~COVID-19~~COVID-19 PHE health emergency. -All clinical and medical necessity review is now ~~being~~ performed electronically and telephonically.
-

Behavioral Health Services

Medi-Cal

CalOptima ~~is responsible for providing~~offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. ~~Behavioral Health (BH)~~ S~~s~~ervices include, but are not limited to,~~:~~ individual and group psychotherapy, ~~psychology,~~ psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima also covers Alcohol Misuse Screening and Counseling (AMSC) services provided to members 18 and older in the primary care setting.

~~In addition,~~ CalOptima covers medically necessary behavioral health treatment (BHT) for members 20 years ~~years of age~~ and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)~~that meet medical necessity criteria~~. BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. ~~are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.~~

~~CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) (formerly Screening, Brief Intervention, and Referral to Treatment [SBIRT]) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.~~

~~CalOptima members can access~~ Most mental health services ~~directly, without~~do not require a physician referral. Members may access mental health services, by ~~contacting~~ calling the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be ~~referred to~~offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

~~CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.~~

CalOptima directly manages all administrative functions of the Medi-Cal ~~mental~~ behavioral health benefits including UM, claims, provider network credentialing ~~the provider network~~, member services and QI.

OC and OCC

~~CalOptima previously contracted with Magellan Health Inc., to directly manage the BH benefits for OC and OCC members. Effective 1/1/2020, OC and OCC covered BH services were fully integrated within CalOptima internal operations. OC and OCC members can access BH services by calling the CalOptima Behavioral Health Line. Members will be connected to CalOptima representative for BH assistance.~~

~~CalOptima offers AMSC services in the PCP setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.~~

CalOptima offers the following mental health services to OC and OCC members:

- Outpatient mental health care including but not limited to individual and group psychotherapy, medication management, psychological testing, intensive outpatient program (IOP), and partial hospitalization program (PHP)~~;~~.
- Inpatient mental health care in either a psychiatric or general hospital.
- Opioid Treatment Program (OTP) services~~; and~~.
- Alcohol Misuse Screening and Counseling (AMSC) services.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the OC and OCC behavioral health benefits including UM, claims, provider network credentialing ~~the provider network~~, member services and QI.

~~LINKAGES WITH COMMUNITY RESOURCES~~

~~IN ADDITION, CALOPTIMA PROVIDES LINKAGES WITH COMMUNITY PROGRAMS TO MEMBERS WITH SPECIAL HEALTH CARE NEEDS, OR HIGH RISK OR COMPLEX MEDICAL AND DEVELOPMENTAL CONDITIONS. THESE LINKAGES ARE ESTABLISHED THROUGH SPECIAL PROGRAMS, SUCH AS THE CALOPTIMA COMMUNITY LIAISONS, PCCS, BH INTEGRATION (BHI), LTSS AND SPECIFIC PROGRAM CONTRACTS AND MOUS WITH OTHER COMMUNITY AGENCIES AND PROGRAMS, SUCH AS THE OC HCA'S CCS, ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH, AND THE REGIONAL CENTER OF ORANGE COUNTY. THE UM STAFF AND DELEGATED ENTITY PRACTITIONERS ARE RESPONSIBLE FOR IDENTIFICATION OF SUCH CASES, AND COORDINATION OF REFERRAL TO APPROPRIATE STATE AGENCIES AND SPECIALIST CARE WHEN THE BENEFIT COVERAGE OF THE MEMBER DICTATES. THE UM DEPARTMENT COORDINATES ACTIVITIES WITH THE CASE MANAGEMENT DEPARTMENT TO ASSIST MEMBERS WITH THE TRANSITION TO OTHER CARE, IF NECESSARY, WHEN BENEFITS END. THIS MAY INCLUDE INFORMING THE MEMBER ABOUT WAYS TO OBTAIN CONTINUED CARE THROUGH OTHER SOURCES, SUCH AS COMMUNITY RESOURCES.~~

AUTHORITY, BOARD~~S OF~~ OF DIRECTORS' COMMITTEES, ~~AND~~ AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC)~~——~~which oversees the functions of the QI Committee described in CalOptima's ~~S~~state and ~~F~~federal Contracts~~——~~and to CalOptima's Chief Executive Officer (CEO), as ~~discussed~~ described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and

~~review and~~ make recommendations to the Board regarding ~~accepting~~ the overall QI Program. QAC ~~and annual evaluation, and~~ routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and ~~improvements achieved~~ ~~Q~~quality performance results. The QAC also makes recommendations to the B~~b~~oard for annual approval with modifications and appropriate resource allocations of the QI Program ~~and actions~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preven~~ta~~tive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons medical safety net
- ~~OC HCA~~
- Orange County Social Services Agency (~~OC~~ SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions held by ~~OC~~ HCA and ~~OC~~ SSA are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)

- CBAS provider representative
- Home-- -and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - ~~OC HCA, Behavioral Health~~
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent ~~a~~ the broad provider community that serves CalOptima members. The PAC ~~is comprised of~~has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of ~~OC~~ HCA, which maintains a standing seat. PAC meets at least quarterly and is~~are~~ open to the public. The 15 seats include:

- Health networks~~N~~
- Hospitals
- Physicians (three~~3~~ seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- ~~OC~~ HCA (one~~1~~ standing seat)
- LTSS (LTC facilities and CBAS) (one~~2~~ seat~~s~~)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

~~In 2018, CalOptima's Board of Directors established the~~ Whole-Child Model Family Advisory Committee (WCM FAC), ~~i~~as has been required by the state as part of California Children's Services (CCS) ~~when~~since it becam~~e coming~~ a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: ~~7–9~~seven to nine seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are ~~a~~ current recipients of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: two~~2~~ to four~~4~~ seats
  - Community-based organizations; or
  - Consumer advocates

Members of the c~~C~~ommittee shall serve staggered two-year terms. ~~Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term.~~ WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director, ~~of~~ Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the s~~S~~tate and f~~F~~ederal c~~C~~ontracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO), ~~along with the Deputy Chief Medical Officer (DCMO)~~ oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO oversees the strategies, programs, ~~policies~~policies, and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services ~~and Supports~~ (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (ED ~~of~~ CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED ~~of~~ CO serves as a member of the executive team, and, with

the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED ~~of~~ CO is expected to anticipate, continuously improve, ~~communicate~~communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Executive Director, Quality & Population Health Management (ED ~~of~~ Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED ~~of~~ Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED ~~of~~ Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Medical Director, Utilization Management is appointed by the CMO and/or DCMO~~,~~ and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program. The medical director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The M~~m~~edical D~~d~~irector ~~of~~ UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral health care practitioner in the QI and UM programs who~~,~~ ~~and s~~serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OC and OCC), MLTSS programs~~,~~ and Case Management ~~and Transitions of Care~~ programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The

medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, -disease management and health education programs, while also providing clinical quality oversight of the PACE Center.

Director, Utilization Management
~~Director~~ is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. -This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. -The incumbent will have oversight of CalOptima's U~~tilization~~ M~~anagement~~ program for CalOptima Community Network, CalOptima Direct and the delegated ~~health network~~HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Services (Integration) is responsible for the planning, organization monitoring and evaluation of all activities and personnel engaged in the BH UM program~~provides operational oversight for BH benefits and services provided to members~~. The director ~~is responsible for monitoring~~ tracks, ~~, analyzing~~analyzes, and reports~~ing~~ to senior staff on changes in the behavioral health care delivery environment and program

o~~o~~pportunities affecting or available to assist CalOptima in integrating physical and BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Behavioral Health Services (Clinical Operations) is responsible for the day-to-day operation of the BH UM program. The director oversees a team of care managers, medical case managers~~,~~ and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED ~~of~~ Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole~~--~~

person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure that CalOptima and its subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and ~~L~~legal ~~C~~counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical

guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years ~~of~~ managed care experience preferred.
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in U~~tilization~~ M~~anagement~~ activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN license or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years ~~of~~ managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted California Board LVN or CA RN license.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience.
- Excellent analytical and communication skills required.

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum ~~of~~ 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum ~~of~~ 2 years of college preferred.
- 2 years ~~of~~ related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum ~~of~~ 2 years of college preferred.
- 2–3 years previous administrative experience preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

- **Monitoring Nurses – UM (Medical Care Manager (LVN)** provide monitoring of referrals and specific UM initiatives to ensure compliance with UM requirements. -Monitoring activities include inpatient and outpatient, WCM, findings on Correction Action Plans (CAPs) from both internal and external audits, as well as identify opportunity for improvement when identified during the monitoring process.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum ~~of~~ 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, ~~including, but not limited to, the contract with the third-party auditor,~~ and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima ~~D~~delegated ~~H~~health ~~P~~plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T)~~,~~ Committee~~.~~, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years~~'~~ experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development

and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in ~~the~~ CalOptima ~~HNs~~ ~~D~~delegated ~~H~~health ~~P~~plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years ~~of~~ experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health care with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health

networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience & Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, ~~NCQA standards,~~ and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience & Education

- A current and unrestricted RN license or LVN license in the State of California.
- Minimum ~~of~~ 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, LTSS is responsible for assisting the LTSS management with the day-to-day operations~~,~~ of the LTSS ~~D~~department~~s~~, specifically with regard to operational and regulatory reports. The incumbent will: (1) lead collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, ~~Long Term Care~~LTC Nursing Facilities, ~~Multi-Purpose Senior Services Program~~MSSP and the ~~In-Home Support Services~~IHSS ~~P~~program to meet regulatory compliance procedures; (2) work with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; (3) gather and validate LTSS data to submit for DHCS reporting requirements and CalOptima Q~~uality~~ I~~mprovements~~ Program; (4) work with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; (5) support long-~~-~~term departmental sustainability efforts; and (6) all other activities related to the development and implementation of the LTSS program.

~~responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. This position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.~~

Experience & Education

- Bachelor's degree in Sociology, Psychology, or Gerontology is required.
- Master's degree in Social Work, Public Health, Gerontology, Health Care Administration, Public Policy, or other related field preferred.
- 5+ years of program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers, LTC ~~F~~facilities and community events.

- ~~Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.~~
- ~~Minimum of 3 years CBAS and program development experience.~~
- ~~Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.~~
- ~~Previous work experience in managing programs and building relationships with community partners is preferred.~~
- ~~Excellent interpersonal skills.~~
- ~~Computer literacy required.~~
- ~~Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).~~

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is

preferred.
- 4 years ~~of~~ supervisor or manager level experience required.
- 1 year experience in behavioral health audits (including CMS, DHCS, Department of Managed Health Care [DMHC] and NCQA).
- 1-year experience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services (Integration), Medical Director, ~~of~~ Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education
- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years of experience working in a managed care environment, with specific experience in BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.
- 2 years ~~of~~ experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years ~~of~~ experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3 or more years of supervisor level experience in clinical management of ABA services is required.
- 3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

Medical Case Managers (BH-RN) are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers~~MCMs~~ adhere to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity and consult with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, ~~utilization management~~UM criteria, and related policies/procedures for authorization and referral requests from B~~ehavioral H~~ealth and ABA providers.~~clinical review and recommendations related to Interdisciplinary Care Team (ICT)~~

~~meetings, inpatient and outpatient psychiatric authorization requests from BH providers and completing inpatient CCR and transitional care for OC and OCC members. They are responsible for adhering to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity, consulting with the manager and Medical Director as needed. They also review prior authorization requests for outpatient mental health services.~~

Experience & Education

- Current and unrestricted RN license to practice in the State of California
- Minimum ~~of~~ 3 years current BH clinical experience or an equivalent combination of education and experience required.
- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes medical criteria, and policies~~,~~ and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers

Experience & Education

- High school diploma required, Associates or Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years ~~of~~ clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in B~~ehavioral H~~~~ealth~~ or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4 or more years providing ABA therapy to children diagnosed with ASD is required.
- Experience in clinical, medical utilization review, and/or quality assurance is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language~~s~~ is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in ~~behavioral health~~BH or related field is preferred.
- 2 years ~~of~~ experience in ~~behavioral health~~BH, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.

Qualifications and Training

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation~~.~~
- HIPAA and Privacy/Corporate Compliance~~.~~
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)~~.~~
- UM Program, policies/procedures, etc.
- MIS data entry~~.~~
- Application of Review Criteria/Guidelines~~.~~
- Appeals Process~~.~~
- Seniors and Persons with Disabilities Awareness Training~~.~~
- OC and OCC Training

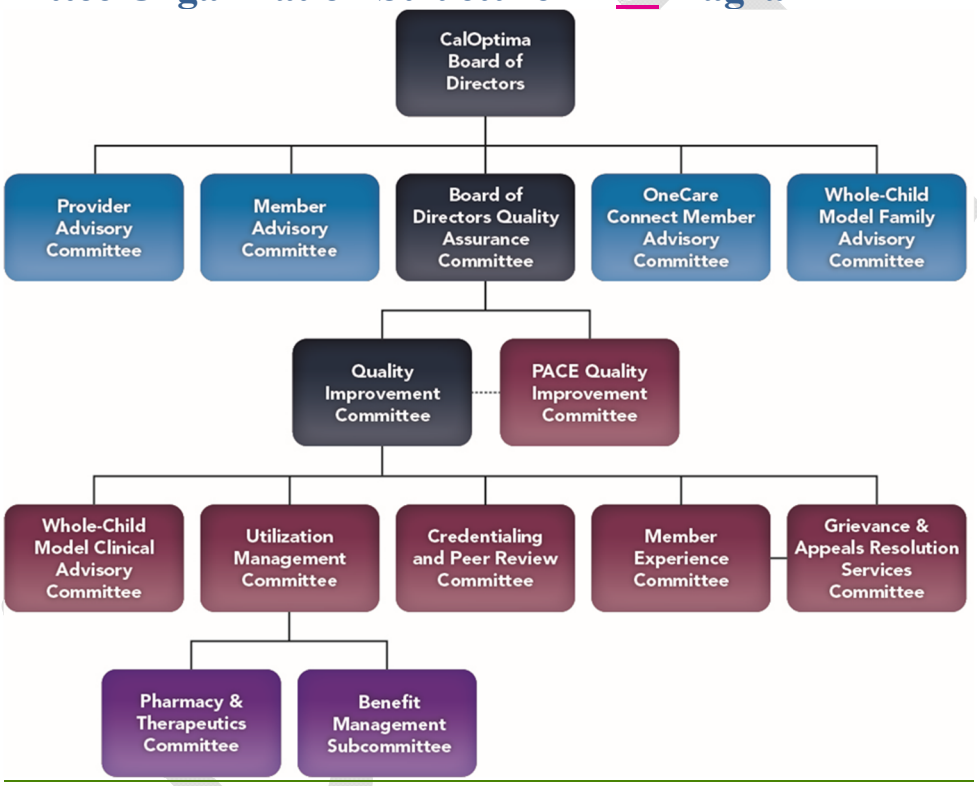
CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of ~~-~~the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. ~~-~~The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to

perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff ~~is~~ are required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2020 Committee Organization Structure Diagram



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources,

and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up to QIC and ultimately to- QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals
  - UM Workgroup
  - LTSS

- Reports to the QIC on a quarterly basis; communicates significant findings and makes

recommendations related to UM issues.

UMC Membership
Voting Members:

- CMO
- Medical Director UM
- Medical Director Behavioral Health
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists~~,~~ and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Medical Director, Whole~~ ~~Child Model
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, ~~Operational Instruction Letters (OILs),~~ Medi-Cal Managed Care Division (MMCD), national and local coverage determinations, All Plan Letters (APLs)~~,~~ and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility ~~of~~ for the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director, Utilization Management~~——~~Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) UM Director in conjunction with the Executive Director ~~of~~ Clinical Services, Chief Medical Officer, and Deputy Chief Medical Director ~~and Utilization Management Medical Director~~ prior to submission for committee review and approval.
- Utilization data, ~~is collected, aggregated, and analyzed~~ including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization. Is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, ~~Managed~~ LTSS Programs, P&T, QI, Credentialing, Compliance~~,~~ and Audit ~~and~~ & Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC, or who otherwise make decisions on UM~~,~~ and quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests~~,~~ file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees~~,~~ including contracted professionals who have access to confidential or member information~~,~~ sign a written statement delineating responsibility for maintaining confidentiality. In addition, all c~~C~~ommittee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member~~,~~ or practitioner~~,~~ specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs~~,~~ and SRGs ~~and~~ hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM PROCESS

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit ~~and~~ & Oversight department via its delegation oversight team for compliance.

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances, relative to appropriate clinical criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of available services within the local delivery system on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means all covered services or supplies that:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with the member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r)~~®~~ and California Welfare and Institutions Code sections 14132(v).
- For Medicare, covered services that are reasonable and necessary for 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 section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for ~~health network~~HN members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, and regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508:~~,~~ Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor

Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.

- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer) or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions,

elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website ~~at www.caloptima.org. .~~Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of~~-~~-network practitioners.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis~~, or~~ options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of~~-~~-network practitioner~~,~~ if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "~~Standing Referral"~~CalOptima policy and procedure, GG.1112: Standing Referral~~-~~ to Specialist Practitioner or Specialty Care Center~~: GG.1112~~, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health

practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.
CalOptima distributes an affirmative- statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the ~~CalOptima Approved Drug List~~ OneCare/Connect (OC/OCC) ~~(~~Formulary~~)~~, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the ~~CalOptima Approved Drug List~~Formulary are communicated to both members and providers. ~~If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:~~

- ~~No formulary alternative is appropriate, and the drug is medically necessary.~~
- ~~The member has failed treatment or experienced adverse effects on the formulary drug.~~
- ~~The member's treatment has been stable on a non-formulary drug and change to a formulary drug is medically inappropriate.~~

~~To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a pharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a clinical pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review~~

Pharmacy Determinations

~~Medi-Cal~~

Medi-Cal

It is expected that, e~~E~~ffective April 1, 2021, the outpatient pharmacy benefit will move to the Medi-Cal fee-for-service program.

~~**CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the P&T. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima pharmacist or Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima pharmacist or Medical Director. CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:**~~

- ~~**A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.**~~
- ~~**An explanation of the appeal process, including the appeal time frames and the member's right to representation.**~~
- ~~**A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.**~~
- ~~**Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.**~~

~~**CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.**~~

OC/OCC

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

~~**Formulary**~~

~~The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the P&T. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.~~

Pharmacy Benefit Manager (PBM)

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, the pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services, and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit ~~and~~ & Oversight department's policies and procedures.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal

CalOptima's BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, ~~Department of Health Care Services~~DHCS

All Plan Letters (APLs), and CalOptima policy (approved by DHCS).

OC/OCC

CalOptima has previously delegated Magellan Health Inc. to directly manage the ~~behavioral health~~BH ~~utilization management~~UM functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's BHI department ~~will~~ performs~~ed~~ prior authorization review functions for OC/OCC covered ~~behavioral health~~BH services. Services that require prior authorization include inpatient psychiatric care, the partial hospitalization program, the intensive outpatient program, ~~,~~ and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPLs), and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed~~-~~ CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM CRITERIA

CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence~~-~~ based standards of care ~~and~~ that include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

–Medi-Cal

1. Federal and State Law Mandates (i.e. Department of Health Care Services – Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
    a. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

2. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

3. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
    a. https://www.uspreventiveservicestaskforce.org/
    b. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and ~~county~~ CCS Program Information Notices for decisions related to CCS and Whole-Child Model.
    a. https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

2. Follow Medi-Cal hierarchy listed above.

~~1. Medi-Cal~~

~~**Federal and state law mandates (i.e. CMS, DHCS)**~~

~~**Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines**~~

~~**EPSDT**~~

~~**Nationally recognized evidence based criteria such as Milliman Care Guidelines (MCG),** U.S.**Preventative Services Task Force recommendations and National Comprehensive Cancer Guidelines, etc.**~~

~~**Transplant Centers of Excellence guidelines**~~

~~**Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology [ACOG] Guidelines,**~~

~~American Medical Association (AMA) and National Guidelines Clearinghouse)~~

~~CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines~~

~~Whole Child Model~~

~~In addition to the Medi-Cal hierarchy above:~~

~~CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.~~

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates –-CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
        i. https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

2. Department of Health Care Services
    a. Medi-Cal Provider Manual
    b. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

3. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

4. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
    a. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

~~1.~~ ~~Medicare~~

~~For OC and OCC:~~

~~1. Federal and state law mandates (i.e. CMD, DHCS)~~
~~2. CMS Guidelines Local and National Coverage Determinations (LCD, NCD)~~
~~3. Medicare Part D: CMS-approved Compendia (for medications)~~
~~4. Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines~~
~~5. Nationally recognized evidence based criteria such as MCG, UpToDate, U.S. Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.~~
~~6. Transplant Centers of Excellence guidelines~~
~~7. Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, ACOG Guidelines, AMA, National Guidelines Clearinghouse)~~
~~8. CalOptima Criteria for outpatient behavioral health services~~
~~9. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines~~

Delegated HNs must utilize Medi-Cal & ~~the same or similar nationally recognized criteria~~Medicare Guidelines, Title ~~XX~~22 of the California Code of Regulations, and national evidenced based guidelines.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse Reviewer**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually / Medi-Cal and Medicare Manuals / CalOptima Pharmacy– – Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient Hhospital Sservices	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X

Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters for WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination.
** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	X		X
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may also be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on a~~n~~ UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

~~**New Technology Review**~~

~~The P&T and BMSC shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.~~

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies ~~with regard to~~regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action.

New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the Ceommittee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number, **888-587-8088**, at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at ~~800-735-2929~~711. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday ~~–~~ Friday are responded to on the same business day.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima. In cases requiring immediate response the vendor staff notifies CalOptima on-call nurse. CalOptima will review and process authorizations outside business hours, as necessary, including decisions to deny or modify authorization requests which are made by CalOptima on-call UM physician~~or notifies CalOptima on-call nurse in cases requiring immediate response~~. A log is forwarded by the vendor to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer
The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise
The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors~~, with the support of the UMC,~~ have the authority, accountability, and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records
During prospective and concurrent telephonic review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to

conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, ~~disease management~~PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical ~~care~~care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options~~;~~.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective ~~or concurrent~~ service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "All information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the 72 hours expedited period to 14 calendar days if the ~~M~~member requests an extension, or if the plan justifies a need. ~~may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:~~ ~~▪ Within 24 hours of receipt of the urgent preservice request~~	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	~~The plan gives the member or member's authorized representative at least 48 hours to provide the information.~~		**Member:** Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination (written notification) **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.
	▪ ~~The extension period, within which a decision must be made by the plan, begins:~~ ○ ~~On the date when the plan receives the member's response (even if not all of the information is provided), *or*~~ ○ ~~At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.~~ **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations:	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	○ The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. ○ Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a decision (NCQA UM 5). ○ A response to defer is required within 24 hours for all services that require prior authorization.	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		~~permitted under Title 42, CFR, Sections 431.213 and 431.214.~~
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified **Member & Practitioner**: None specified **Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
Hospice — Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

Medicare ~~(Excludes Pharmacy Requests)~~

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later than upon expiration of extension.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	~~than upon expiration of extension.~~

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal	OC and OCC
Processed by CalOptima Pharmacy Management department or Pharm Benefits Manager	Processed by CalOptima Pharmacy Management department

Medi-Cal	OC and OC C

Standard (Non-urgent) Preservice: Within 24 hours a decision to appro modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed: Within 5 workin days of receiving needed informatio but no longer than 14 calendar days** **Expedited (Urgent) Preservice/Concurrent: Within 24 h a decision to approve, modify, deny**	**Routine: 72 hours** **Urgent: 24 hours** **Retrospective: 14 days**

Medi-Cal	OC and OCC
Pre-Service and Concurrent Appro Provider: Electronic/written: Withi hours of making the decision. Pre-Service and Concurrent Denial Provider: Electronic/written: Withi hours of making the decision. Member: Written: Within 2 busines days of making the decision. Post Service/ Retrospective Approv Practitioner: Written: Within 30 da of receipt of request. Post Service/ Retrospective Denials:	Authorization Request Type: For expedited requests: Written notification must be provid to the member within 24 hours fron receipt of the request. If initial notification is made orally, then wri notification must be provided withi calendar days of the oral notificatio For standard requests: Written notification must be provid to the member within 72 hours fron receipt of the request. If initial notification is made orally, then wri notification must be provided withi calendar days of the oral notificatio For retrospective requests: Written notification must be provid to the member within 14 calendar d

Emergency Services

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A non-contracted hospital must submit a Prior Authorization Request for Post-Stabilization Inpatient Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) do not apply to contracted -providers relative to CalOptima's Medi-Cal Program. CalOptima or a HN shall approve or ~~deny within 30 minutes after receiving~~ a -prior authorization request for post-~~-~~stabilization services and all information reasonably necessary and requested to render a decision from a non-contracted hospital within 30 minutes after receiving such request and information for Medi-Cal members, ~~,~~and within 60 minutes after receiving such request and ~~information from~~information from a non-contracted hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed time frame, medically necessary post-stabilization inpatient services are considered approved.

Prior Authorization Services

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director~~, UM~~UM, or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

~~In addition to authorization for post-stabilization services that often result in an inpatient admission,~~ F~~f~~acilities are ~~also~~ required to notify CalOptima of all inpatient prior-authorized admissions within 1 business day following the actual admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the

request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre--service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in CalOptima policy GG.1508: Authorization and Processing of Referrals. The written notification is written in lay language that is easily understandable at the 6th grade level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

Grievance and Appeal Process

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OC C members wish to exercise their right to review ~~a~~ the UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of ~~-~~information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a

State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage,

and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

Long-Term Services and Supports

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A, ~~and~~ NF-B, and sub-acute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: Onsite NFs where CalOptima nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when a member's needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, ~~or~~ in response to individual facility requests, and when new programs are implemented.

CBAS
An outpatient, facility-based program offering day-time care and health and social services~~,~~ to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP
CalOptima has responsibility for the payment of ~~the~~ MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

TRANSITIONS OF CARE

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from Fountain Valley Regional Hospital (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre~~-~~-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the ~~2019~~ current Case Management Program

document.

Transplant Program

The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM, the Clinical Performance Excellence Committee, identified ~~and~~stakeholders and reported to UMC. The UMC reviews the Over/Under Utilization Dashboard on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization. ~~Measures are monitored and reviewed for over and underutilization, and/or changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.~~Over and Under Utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed ~~D~~days
- Admits per 1000
- Average ~~L~~length of ~~S~~stay
- Readmission ~~R~~rates
- Denial ~~R~~rates
- Pharmacy ~~U~~utilization ~~M~~measures
- Appeal ~~O~~overturn ~~R~~rates~~ ~~P~~provider per 1000 per ~~Y~~year
- Member grievances per thousand
- Outliers from Fraud, Waste & Abuse investigations
- Select HEDIS rates for selected measures
- PCP & ~~S~~specialist referral pattern analysis
- Member utilization patterns
- Trends in UM related complaints
- Potential ~~Q~~quality ~~I~~issues
- Behavioral ~~H~~health measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- ~~(~~DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to the CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS),; member/provider complaints and appeals that relate specifically to UM,; provider satisfaction surveys with specific questions about the UM process,; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

2021
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Back to Agenda Back to Item

2021 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

Andrew Do **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members is in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry- recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members'

health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures**,** including providing opportunities for stakeholder input.
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services
Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs
To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OneCare (OC) to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare , CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi- Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community- based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)

COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy. Additionally, UM requirements for COVID PHE screening, vaccinates and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. WPC is scheduled to terminate December 31, 2020, however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicare Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely**.** Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC, who are also eligible for the HHP, to continue with their current WPC providers for their housing- related services.

Homeless Health Initiative (HHI)

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

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the county. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with Whole-Person Care and Board of Director's authorization to extend the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole Person Care program. The grant funds have been exhausted.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 PHE, these services are available via telehealth, in addition to in person.
- Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. CalOptima provides preventive screenings, chronic care, care coordination and follow up.
- Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

Effective April 1, 2021, the Department of Health Care Service (DHCS) is carving out the outpatient

pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/ prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect the OneCare or OneCare Connect and lines of business and PACE Program.

Virtual Care Strategy

In 2021, federal and state rules and regulations provided limited waivers for telehealth due to the COVID-19 PHE, that enabled CalOptima to accelerate its virtual care strategy under COVID-19 PHE shelter-at-home measures. Members were able to receive appropriate health care services through telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.
2. Leverage existing delivery model where possible.
3. Be proactive in seeking out opportunities to innovate.
4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 20210 are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member - focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma- Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals

- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, will be developed and implemented.

With Whom We Work

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs providing health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs, representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for members to select, supplementing the HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	

AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on Medical Necessity and/or benefit coverage.
- Identify and refer high-risk members to Case Management programs, including Complex Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate practitioners and other providers, including delegated HNs on CalOptima's UM Program, policies and procedures on an ongoing basis.
- Monitor utilization practice patterns of practitioners to identify variations from the standard

practice that may indicate need for additional education or support.
- Continuous identification of UM staff needs, and appropriate training delivered to address those needs, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality- based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:
- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs' UM activities by the Audit and Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for

Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

LONG-TERM SUPPORT SERVICES

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- In April 2020, all LTC member facility clinical reviews and medical necessity nursing facility visits were suspended due to the COVID-19 PHE. All clinical review is now performed electronically and telephonically.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). In April 2020 all CBAS member and facility clinical reviews and medical necessity visits were suspended due to the Public Health Emergency COVID-19PHE All clinical and medical necessity review is now performed electronically and telephonically.
- MSSP: Home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020 all MSSP member and facility clinical reviews and medical necessity visits were suspended due to the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.

Behavioral Health Services

Medi-Cal
CalOptima offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Services include but are not limited to individual and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima also covers Alcohol Misuse Screening and Counseling (AMSC) services provided to members 18 and older in the primary care setting.

CalOptima covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

Most mental health services do not require a physician referral. Members may access mental health services, by calling the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

OC and OCC
CalOptima offers the following mental health services to OC and OCC members:

- Outpatient mental health care including but not limited to individual and group psychotherapy, medication management, psychological testing, intensive outpatient program (IOP), and partial hospitalization program (PHP).
- Inpatient mental health care in either a psychiatric or general hospital.
- Opioid Treatment Program (OTP) services.
- Alcohol Misuse Screening and Counseling (AMSC) services.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the OC and OCC behavioral health benefits including UM, claims, provider network credentialing , member services and QI.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's state and federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support

- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons — medical safety net
- Orange County Social Services Agency (SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs — behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee
The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - SSA
    - OC Community Resources Agency, Office on Aging
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
Whole-Child Model Family Advisory Committee (WCM FAC), has been required by the state as part of California Children's Services (CCS) when it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: seven to nine seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: two to four seats
    - Community-based organizations; or
    - Consumer advocates

Members of the committee shall serve staggered two-year terms. WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several

departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO), oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO oversees the strategies, programs, policies, and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Medical Director, Utilization Management is appointed by the CMO and/or DCMO and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program. The medical director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the

bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral health care practitioner in the QI and UM programs who serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OC and OCC), MLTSS programs and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's UM program for CalOptima Community Network, CalOptima Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Services (Integration) is responsible for the planning, organization monitoring and evaluation of all activities and personnel engaged in the BH UM program. The director tracks, analyzes, and reports to senior staff on changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Behavioral Health Services (Clinical Operations) is responsible for the day-to-day operation of the BH UM program. The director oversees a team of care managers, medical case managers and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure that CalOptima and its subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and legal counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.

- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN license or LVN license in the State of California.

- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education
- Current and unrestricted California Board LVN or CA RN license.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience.
- Excellent analytical and communication skills required.

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- Current and unrestricted California Board LVN or RN license.
- Minimum 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- High school graduate or equivalent; a minimum 2 years of college preferred.
- 2 years related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum 2 years of college preferred.
- 2–3 years previous administrative experience preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

Monitoring Nurses – UM (Medical Care Manager (LVN)) provide monitoring of referrals and specific UM initiatives to ensure compliance with UM requirements. Monitoring activities include monitoring referrals including inpatient and outpatient, WCM, findings on Correction Action Plans (CAPs) from both internal and external audits, as well as identify opportunity for improvement when identified during the monitoring process.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics

(P&T) Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health care with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health

networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience & Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience & Education

- A current and unrestricted RN license or LVN license in the State of California.
- Minimum 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department, specifically with regard to operational and regulatory reports. The incumbent will: (1) lead collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, LTC Nursing Facilities, MSSP and the IHSS program to meet regulatory compliance procedures; (2) work with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; (3) gather and validate LTSS data to submit for DHCS reporting requirements and CalOptima QI Program; (4) work with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; (5) support long-term departmental sustainability efforts; and (6) all other activities related to the development and implementation of the LTSS program.

Experience & Education

- Bachelor's degree in Sociology, Psychology, or Gerontology is required.
- Master's degree in Social Work, Public Health, Gerontology, Health Care Administration, Public Policy, or other related field preferred.
- 5+ years of program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers, LTC facilities and community events.

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is preferred.
- 4 years supervisor or manager level experience required.
- 1 year experience in behavioral health audits (including CMS, DHCS, Department of Managed Health Care [DMHC] and NCQA).
- 1-year experience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services (Integration), Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education

- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years of experience working in a managed care environment, with specific experience in BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.

- 2 years experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3 or more years of supervisor level experience in clinical management of ABA services is required.
- 3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

Medical Case Managers (BH-RN) are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers adhere to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity and consult with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, UM criteria, and related policies/procedures for authorization and referral requests from BH and ABA providers.

Experience & Education
- Current and unrestricted RN license to practice in the State of California
- Minimum 3 years current BH clinical experience or an equivalent combination of education and experience required.
- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes medical criteria, and policies and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers

Experience & Education
- High school diploma required, Associates or Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in BH or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4 or more years providing ABA therapy to children diagnosed with ASD is required.
- Experience in clinical, medical utilization review, and/or quality assurance is preferred.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in BH or related field is preferred.
- 2 years experience in BH, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.

Qualifications and Training

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

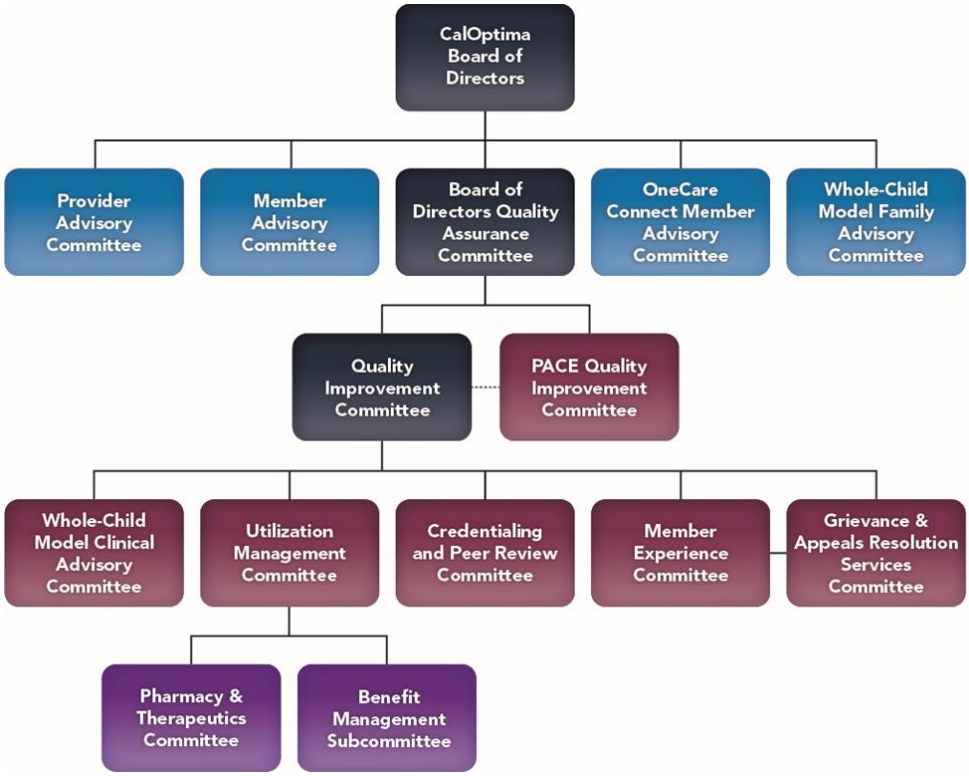
- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training
- OC and OCC Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff are required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2021 Committee Organization Structure — Diagram



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up to QIC and ultimately to QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM program,

consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HNs.

- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals
  - UM Workgroup
  - LTSS

- Reports to the QIC on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

UMC Membership

Voting Members:

- CMO
- Medical Director UM
- Medical Director Behavioral Health
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Medical Director, Whole-Child Model
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director, Utilization Management — Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.

- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, LTSS Programs, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs and SRGs hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM Process

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit & Oversight department via its delegation oversight team for compliance.

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances appropriate clinical criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of available services within the local delivery system on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means all covered services or supplies that:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d® and California Welfare and Institutions Code sections 14132(v).
- For Medicare, covered services that are reasonable and necessary for 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 section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided

health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508: Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.

- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer) or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the

CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of- network practitioners.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "CalOptima policy and procedure, GG.1112: Standing Referral to Specialist Practitioner or Specialty Care Center, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and

professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.
CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Pharmaceutical Management

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the OneCare/Connect (OC/OCC) Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations

Medi-Cal
Effective April 1, 2021, the outpatient pharmacy benefit will move to the Medi-Cal fee-for-service program.

OC/OCC
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal
CalOptima's BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers

and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, DHCS All Plan Letters (APL), and CalOptima policy (approved by DHCS).

OC/OCC
CalOptima has previously delegated Magellan Health Inc. to directly manage the BH UM functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's BHI department performed prior authorization review functions for OC/OCC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL), and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM Criteria

CalOptima conducts Utilization Review using UM criteria for medical, BH, and pharmacy medical necessity decisions that are nationally recognized, evidence- based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

Medi-Cal

1. Federal and State Law Mandates (i.e. Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
   a. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

2. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
   a. https://www.nccn.org/professionals/physician_gls/default.aspx

3. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
    a. https://www.uspreventiveservicestaskforce.org/
    b. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole-Child Model.
    a. https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

2. Follow Medi-Cal hierarchy listed above.

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates - CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
        i. https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

2. Department of Health Care Services
    a. Medi-Cal Provider Manual
    b. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

3. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

4. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
    a. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Delegated HNs must utilize Medi-Cal & Medicare Guidelines, Title 22, and national evidenced based guidelines.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse Reviewer**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient Hospital Services	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X

Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters for WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria and no clinical judgment is required.

** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	**X**		**X**
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for

performance below the established benchmark of 90% are discussed and recommendations taken from the Committee.

Provider and Member Communication

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **711**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima. In cases requiring immediate response the vendor staff notifies CalOptima on-call nurse. CalOptima will review and process authorizations outside business hours, as necessary, including decisions to deny or modify authorization requests which are made by CalOptima on-call UM physician. A log is forwarded by the vendor to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective and concurrent review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of

care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "All information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the 72 hours expedited period to 14 calendar days if the member requests an extension, or if the plan justifies a need.	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
			Member: Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination (written notification) **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.
	Expedited (Urgent) Pre-Service request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations: o Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or o In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. ○ Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a decision (NCQA UM 5). ○ A response to defer is required within 24 hours for all services that require prior authorization.	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request.	**Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
	Additional Information Received: If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Member & Practitioner**: None specified	
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified	
Hospice — Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

Medicare

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later than upon expiration of extension.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal	OC and OCC
Processed by CalOptima Pharmacy Management depart Pharmacy Benefits Manager Qualified pharmacist or physician review for any modif or denials Qualified physician review for any appeals	Processed by CalOptima Pharmacy Management Department Qualified pharmacist or physician review for any modifications or denials Qualified physician review for any appeals

Medi-Cal	OC and OC C
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. Standard (Non-urgent) Preservice, Extension Needed: Within 5 working days of receiving needed information, but no longer than 14 calendar days Expedited (Urgent) Preservice/Concurrent: Within 24 hours a decision to approve, modify, deny or defer is required. Expedited (Urgent) Preservice/Concurrent, Extension Needed: Within 72 hours of the initial request Post-Service/Retrospective: Within 30 days of receipt	Routine: 72 hours Urgent: 24 hours Retrospective: 14 days

Medi-Cal	OC and OCC
Pre-Service and Concurrent Approvals: Provider: Electronic/written: Within 24 hours of making the decision. Pre-Service and Concurrent Denials: Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 2 business days of making the deci Post Service/ Retrospective Approvals: Practitioner: Written: Within 30 days of receipt of request. Post Service/ Retrospective Denials: Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of receipt of request.	Authorization Request Type: For expedited requests: Written notification must be provided to the member within 2 from the receipt of the request. If initial notification is made o then written notification must be provided within 3 calendar d the oral notification. For standard requests: Written notification must be provided to the member within 7 from the receipt of the request. If initial notification is made o then written notification must be provided within 3 calendar d the oral notification. For retrospective requests: Written notification must be provided to the member within 1 calendar days from the receipt of the request. If initial notifica made orally, then written notification must be provided within calendar days of the oral notification.

Emergency Services

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A non-contracted hospital must submit a Prior Authorization Request for Post-Stabilization Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) do not apply to contracted providers relative to CalOptima's Medi-Cal Program. CalOptima or a HN shall approve or deny a prior authorization request for post- stabilization services and all information reasonably necessary and requested to render a decision from a non-contracted hospital within 30 minutes after receiving such request and information for Medi-Cal members, and within 60 minutes after receiving such request and information from a non-contracted hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed time frame, medically necessary post-stabilization inpatient services are considered approved.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior

authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director UM, or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

Facilities are required to notify CalOptima of all inpatient prior-authorized admissions within 1 business day following the actual admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each

hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial, or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in CalOptima Policy GG.1508: Authorization and Processing of Referrals. The written notification is written in lay language that is easily understandable at the 6th grade level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

Grievance and Appeal Process

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OC C members wish to exercise their right to review the UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the

termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

Long-Term Services and Supports

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A, NF-B, sub-acute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: Onsite NFs where CalOptima nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when a member needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at

center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP
CalOptima has responsibility for the payment of MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

TRANSITIONS OF CARE

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from acute care hospitals (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the current Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are

managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM, the Clinical Performance Excellence Committee, identified stakeholders and reported to UMC. The UMC reviews the Over/Under Utilization Dashboard on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization. Over and Under Utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed days
- Admits per 1000
- Average length of stay
- Readmission rates
- Denial rates
- Pharmacy utilization measures
- Appeal overturn rates — provider per 1000 per year

- Member grievances per thousand
- Outliers from Fraud, Waste & Abuse investigations
- Select HEDIS rates for selected measures
- PCP & specialist referral pattern analysis
- Member utilization patterns
- Trends in UM related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

15. Consider Approval of Modifications to Quality Improvement Policies

Contacts

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

Recommend approval of modifications to the following CalOptima policies pursuant to CalOptima's annual review process:

- GG.1603: Medical Records Maintenance
- GG.1611: Potential Quality Issue Review Process
- GG.1615: Corrective Action Plan for Practitioners
- GG.1658: Suspend, Restrict or Terminate Practitioner Participation in CalOptima's Network

Background/Discussion

Modifications to Existing Quality Improvement Policies and Procedures and New GG.1658
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.

The following Quality Improvement policies require modifications:

- ***GG.1603: Medical Records Maintenance [Medi-Cal, OneCare, OneCare Connect]*** defines the minimum standards for maintaining a Member's Medical Records. CalOptima staff revised this policy pursuant to the CalOptima annual review process and includes revised language to align with 2020 DHCS Medical Record Review Standards, added additional APL references, regulatory codes, medical record definition, and line of business definitions. Primary care practitioner and telehealth definitions were also modified.
- ***GG.1611: Potential Quality Issue Review Process [Medi-Cal, OneCare, OneCare Connect]*** defines the process for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Quality Improvement (QI) department. CalOptima staff revised this policy pursuant to the CalOptima annual review process, and added specificity to time frames for reviews, medical record response from provider, and target to close cases. Staff also added clarity regarding cases that are submitted anonymously, and updated several letters that were attached to the policy. Revisions include incorporation of PQI leveling definitions from policy GG.1612 into GG.1611. Once incorporated, GG.1612 will be retired.

- ***GG.1615: Corrective Action Plan for Practitioners [Medi-Cal, OneCare, OneCare Connect and PACE]*** defines the appropriate action process that CalOptima shall use for practitioners, including routine monitoring, investigation, and corrective action related to their clinical

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practice. CalOptima staff revised this policy to better define how practitioners are monitored, investigated and how appropriate action is taken for non-medical and medical disciplinary causes or reasons. A new policy (GG.1658) was developed from GG.1615 to address summary suspensions or restrictions for medical disciplinary cause or reason. In the procedure section, a section was added to include non-medical disciplinary corrective actions which are not reportable, and a section to address medical disciplinary causes or reasons which references new policy GG.1658.

- ***GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network [Medi-Cal, OneCare, OneCare Connect and PACE]*** is a new policy that defines the process CalOptima uses to impose a summary suspension or restriction on a practitioner for a medical disciplinary cause or reason. GG.1658 was developed to address summary suspensions and restrictions for medical disciplinary cause or reason.

Fiscal Impact
The recommended action to approve revisions to CalOptima Policies GG.1603, GG.1611, GG.1615 and GG.1658 is operational in nature and is not expected to have any fiscal impact.

Rationale for Recommendation
The recommended action will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policies will supersede the prior versions.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee (Anticipated February 25, 2021) Approved 2/25/2021

Attachments
1. GG.1603: Medical Records Maintenance Final Policy Packet
2. GG.1611: Potential Quality Issue Review Process Final Policy Packet
3. GG.1615: Corrective Action Plan for Practitioners Final Policy Packet
4. GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network Final Policy Packet

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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Policy #: GG.1603
Title: **Medical Records Maintenance**
Department: Medical ~~Affairs~~Management
Section: Quality Improvement

CEO Approval: ~~Michael Schrader~~ _____

Effective Date: 10/01/1995
Revised Date: ~~03/01/2019~~ TBD

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☐ PACE
☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's~~*~~ Medical Records.

II. POLICY

A. A Practitioner and Provider shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

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

b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable; ~~and~~

viii. ~~Preferred~~Primary language~~,~~ and linguistic service needs~~, and the request~~ of non-or ~~refusal of~~limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language ~~assistance~~and/or interpretation services by a non-or limited-English proficient member are documented, as applicable. Member refusal of interpreter services may be documented at least once and be accepted throughout the Member's care, unless otherwise specified; and

~~viii.~~x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

2) Treatment;

3) Discharge instructions; and

4) Recommended follow-up.

~~i. Initial Health Assessment (IHA);~~

~~ii.~~i. ~~Initial Individualized Health Education Behavioral Assessment (IHEBA);~~

~~xiii. If a **Member** is eighteen (18) years of age or older, documentation of whether the **Member** has been informed and has executed an advance directive;~~

~~xiv. Signed consent form or statement for any invasive procedure;~~

~~ii. Authorization Request Forms (ARFs);~~

~~iii.~~ii. ~~Referrals;~~

~~iv.~~ii. ~~Significant telephone advice, documented with date, time, and signature;~~

~~xv. Consultation reports; and~~

~~xvi.~~xiii. Prescriptions.

c. Preventive Care

~~iii.~~i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

~~iv.~~ Preventive care and health maintenance services rendered;

ii.

~~v.~~ Initial Health Assessment (IHA);

iii.

~~vi.~~ Initial Individualized Health Education Behavioral Assessment (IHEBA);

iv.

~~vii.~~ Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

v.

~~viii.~~

~~ix.~~ Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

vi.

~~x.~~

vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

~~d.~~e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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

~~A.~~C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal~~
~~C.~~D. CalOptima Contract for Health Care Services
~~D.~~E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
~~E.~~F. CalOptima Policy GG.1618: Member Request for Medical Records
~~F.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
G. Department of Health Care Services (DHCS) Policy Letter (PL) 99-003: Cultural and ~~Linguistic~~Linguistics
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004: Immunization Requirements
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009: Telehealth Services Policy
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006: Site Reviews: Facility Site Review and Medical Record Review
~~H.~~L. Title 22, California Code of Regulations~~,~~ (CCR), §75055
~~I.~~M. Title 28, California Code of Regulations~~,~~ (CCR), §§1300.67.1(c) and 1300.80(b)(4)
~~J.~~N. Title 42, United States Code, §1396a(w)
~~K. California Assembly Bill 1688 (Chapter 511, Section 2), Statutes of 2017)~~
O. California Welfare & Institutions Code §14124.1
P. California Probate Code §§ 4701 and 4780-4785
Q. California Business and Professions Code §2290.5
R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100
S. Standards for Determining Threshold Languages and Requirement For Section 1557 Of The Affordable Care Act (APL) 17-011

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/10/10	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
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.
Individualized Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy. OneCare / OneCare Connect: 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 enrolled in ~~of~~ a CalOptima program.
Practitioner	A licensed independent 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), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~ Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a ~~non~~Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model

Term	Definition
	beneficiaries, a PCP may also be a ~~specialists~~specialty care provider or clinic ~~in accordance with W & I Code 14182(b)(11).~~.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.
~~Provider~~Telehealth	~~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.~~The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Policy #:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner and Provider shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

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b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable;

viii. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language and/or interpretation services by a non-or limited-English proficient member are documented, as applicable. Member refusal of interpreter services may be documented at least once and be accepted throughout the Member's care, unless otherwise specified; and

x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

2) Treatment;

3) Discharge instructions; and

4) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

iii. Initial Health Assessment (IHA);

iv. Initial Individualized Health Education Behavioral Assessment (IHEBA);

v. Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

vi. Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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 Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract for Health Care Services
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F. CalOptima Policy GG.1618: Member Request for Medical Records
G. Department of Health Care Services (DHCS) Policy Letter (PL) 99-003: Cultural and Linguistics
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004: Immunization Requirements
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R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100
S. Standards for Determining Threshold Languages and Requirement For Section 1557 Of The Affordable Care Act (APL) 17-011

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

05/10/10	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
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Term	Definition
	supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

PURPOSE

This policy defines the process for reviewing and processing of a Potential Quality Issue (PQI~~), including Quality of Care (QOC) issues,~~) referred to the CalOptima Quality Improvement (QI) Department.

POLICY

A. All CalOptima departments, Practitioners, Providers, Health Networks, and ~~HDOs~~Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the CalOptima Quality Improvement (QI) Department for review and investigation.

~~1. If a Member chooses to remain anonymous, the PQI case will be opened by QI staff and flagged as confidential.~~

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI ~~Nurses~~nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request ~~Medical Records~~medical records and/or other CalOptima records as well as pertinent documentation from Providers, ~~including but not limited to individual Primary Care Physician (PCP) offices, Health Network main offices, hospitals, Skilled Nursing Facilities (SNF), or other Health Delivery Organizations (HDOs). The QI Department shall conduct a medical review, case review, or both.~~as needed.

~~D. CalOptima shall score a PQI case in accordance with CalOptima Policy GG.1612A: Outcome Scores for Potential Quality Issues.~~

~~E.~~D. CalOptima's Chief Medical Officer (CMO~~),~~) or Designee~~,~~ shall refer PQI cases to the CalOptima Credentialing and Peer Review Committee (CPRC) for further evaluation and action, ~~as necessary, in accordance with~~pursuant to the CalOptima ~~QI Plan~~Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and HDO PQI data every six (6) months to identify emerging patterns. This data shall be reviewed by the CMO~~,~~ or Designee~~,~~ who shall report any issues and/or emerging patterns to the CalOptima CPRC for further evaluation and action, as necessary.

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F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima CPRC.

G. The CPRC shall report a summary of trends and activities ~~and findings~~ to the CalOptima Quality Improvement Committee (QIC) and to the Board of Directors' Quality Assurance Committee (QAC).

H. CalOptima shall maintain confidentiality of quality improvement case review information, in accordance this ~~policy~~Policy.

PROCEDURE

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and HDOs may identify and refer a PQI to CalOptima's QI Department.

2. A PQI may be referred from an internal CalOptima department, including but not limited to, Grievance & Appeals Resolution Services (GARS), Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management (UM) ~~Concurrent Review, and~~), Case Management and Compliance.

~~a. If a CalOptima department refers the PQI case, the department shall identify if the Member chooses to remain anonymous.~~

3. ~~All PQI referrals received shall be entered into CalOptima's care management system by QI intake staff and a quality of care (QOC) case shall be opened.~~ Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

a. ~~Upon receipt of~~ Any entity referring a PQI ~~referral,~~case, shall identify if the Member chooses to remain anonymous.

4. A QI Nurse shall perform an initial clinical review within three (3) business days and determine:

a. If the case is a Quality of Care (QOC) or Quality of Service (QOS) based on the initial information received; and

b. If the Member has any urgent clinical issues, care coordination will be provided by the QI Nurse.

B. Process, Review and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima PQI team and documented in CalOptima's care management system.

a. The CalOptima PQI team shall send an acknowledgement letter to the Member.

b. If the ~~shall~~ Member chooses to remain anonymous, the case will be flagged as confidential and no acknowledgement letter will be sent to the Member~~, and~~.

~~a.~~ If the case ~~shall be~~was not referred ~~to a QI Nurse to assess and review for potential Quality of Care (QOC) issues.~~ by

b.c. If the case is determined by the QI Nurse to be Quality of Service (QOS), the case shall be closed and a resolution letter shallMember or a Member's representative, no acknowledgement letter will be sent to the Member.

i. If the case was referred by an internal CalOptima department, notification of the QOS determination will be communicated to the referring department for educational purposes.

c. If theThe QI Nurse determines the case to be a potential QOC issue, the case will be prepared by the QI Nurse for medical review by a CalOptima Medical Director.

B. Medical Review Process

i. A CalOptima QI Nurse shall perform the QOC case review.

a.d. The CalOptima QI Departmentnurse shall request copies of pertinent Medical Recordsmedical records and a response to the Member's complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or HDO(s) that rendered medical services or were involved in rendering the medical service(s).), as needed. A Provider, Practitioner, Health Network, or HDO shall submit such records and response to the CalOptima QI Department within seven (7fourteen (14) calendar days after receipt of the request.

ii.i. If a Provider, Practitioner, Health Network, or HDO fails to respond within the required timeframe:

a) The CalOptima QI Department shall follow-up with a minimum of three (3) attempts within thirty (30) business days to obtain the requested information.

b) CalOptima may request a written and signed explanation for any delay in submitting records or responding to a request for a case review. This document shall become a permanent part of the review record.

c) If there is no reasonable or acceptable explanation provided by the Provider, Practitioner, Health Network, or HDO, or if the delay continues, CalOptima's QI Department, in consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of MembersMember, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

1.2. CalOptima's QI Department may deem it appropriate to deploy CalOptima's copying vendor to copy and provide medical records.

2.3. CalOptima's QI Department shall target to complete its review upon the receipt of the case review response, medical records, and/or other supporting documentation, within one hundred twenty (120) calendar days.

C. Evaluation of Findings and Determination of IfAction of Medically Related Issues

4. ~~Upon receipt of satisfactory documentation from~~ the ~~Provider, Practitioner, Health Network, or HDO identified in~~case is determined by the QI Nurse to be QOS, the case shall be closed and a resolution letter will be sent by the PQI ~~case, a QI Nurse~~team.

   a. If the case was referred by an internal CalOptima Department, notification of the QOS determination will be communicated to the referring department for educational purposes.

   b. The CalOptima PQI team shall ~~evaluate~~send a resolution letter to the Member.

   c. If the Member chooses to remain anonymous, the case~~, review,~~ will be flagged as confidential and ~~summarize any~~no resolution letter will be sent to the Member.

   d. If the case was not referred by a Member or a Member's representative, no resolution letter will be sent to the Member.

~~3.~~5. If the case is determined by the QI Nurse to be QOC, findings will be summarized for evaluation by ~~a~~the CalOptima Medical Director.

~~4.~~6. ~~Upon review, the~~ CalOptima Medical Director shall ~~summarize the case findings and determine~~review with QOC case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the QOC case that reflects the severity ~~level of the case, in accordance with CalOptima Policy GG.1612: Outcome Score for Potential Quality Issues.~~of the outcome.

Outcome Score	Description of Outcome Score
0	No quality of care or quality of service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
H1	Potential clinical care issue with or without an adverse outcome which occurs in a hospital.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.
HDS	Healthcare delivery system issue with or without an adverse outcome.

~~5.~~7. CalOptima shall utilize an external review entity if a second opinion is determined to be needed by a Medical Director.

~~6.~~8. If the CalOptima Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

~~7.~~9. If the CalOptima Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Medical Director or be presented to the CalOptima CPRC for recommendation(s).

a. Higher severity cases will be presented to CPRC for discussion and ~~determination~~recommendation of ~~a CAP~~action.

b. Other cases may be presented to CPRC upon Medical Director's discretion.

~~8.~~10. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC ~~shall:~~may recommend further action.

a. ~~Request~~A corrective action from the specific CalOptima department, Health Network, HDO, Practitioner, or Provider;

b. Require the Practitioner, Provider, Health Network, HDO, or CalOptima department to perform additional educational training; or

c. Require other appropriate action(s) as recommended by the CPRC.

~~9.~~11. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, HDO, Practitioner, Provider, or CalOptima ~~department~~Department.

12. Once the review process is completed, a resolution letter will be sent to the Health Network, the Provider and the Member, if the case was member-generated and not a confidential case.

~~D.~~C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC:

a. Practitioners, Providers, and HDOs whose PQI rate ~~in the last three (3) years is two (2) standard deviations above the mean~~is greater than practitioner, provider or HDO specialty;

~~b. Quarterly Health Network reports forwarded to the Health Networks;~~

~~c.~~ Open and closed cases;

~~d.~~b. ~~Number of referrals from CalOptima departments;~~ and

~~e.~~c. Severity levels and categories of issues.

2. The QI Department shall submit all case findings and recommended actions to the CalOptima CPRC.

3. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

4. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the Quality Improvement Committee (QIC) on a quarterly basis.

5. Additionally, the CalOptima CMO, his or her Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIC to the CalOptima Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima QI Plan.

6. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

7. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

8. The QI Department shall submit a quarterly report to the Health Networks, reporting ~~the status of~~ all closed PQIs affiliated with the specific Health Network.

ATTACHMENT(S)

A. Medical Records Request Form
B. Potential QOC Issue Request for Information Template
C. Health Network ~~Notification~~Resolution Letter
D. Member Resolution Letter (Medi-Cal) ~~MM-16-24_11.28.16~~
E. Member Resolution Letter (OneCare)
F. Member Resolution Letter (OneCare Connect)
~~E.~~G. Member Acknowledgement Letter (Medi-Cal) ~~MM-17-12_11.28.16~~
~~F.~~H. Member Acknowledgement Letter (OneCare)
~~G.~~I. Member Acknowledgement Letter(OneCare Connect)
~~H.~~J. Provider Resolution Letter

REFERENCE(S)

A. California Business and ~~Professional~~Professions Code, §§805 and 1000-1
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
D. CalOptima Three-way Agreement with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~E. CalOptima Policy GG.1612: Outcome Score for Potential Quality Issues~~
~~F.~~E. CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners
~~G.~~F. CalOptima Quality Improvement Plan
~~H.~~G. Title 22, California Code of Regulations (C.C.R), ~~§§52280 and~~ §51051
~~I.~~H. Title 28, California Code of Regulations (C.C.R), §1300.~~70~~85.1
~~J.~~I. Title 42, Code of Federal Regulations (C.F.R), §422.152(~~f~~a)(3), (c)(2), and (d)
J. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/23/2015	Department of Health Care Services (DHCS)
03/28/2016	Department of Health Care Services (DHCS)

BOARD ACTION(S)

None to Date

REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

GLOSSARY

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 Committee (QIC).
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. For the purposes of this policy, a designee acting on behalf of the CalOptima Chief Medical Officer (CMO) shall be a CalOptima Medical Director.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), 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~~members assigned to that Health Network.
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Member	An enrollee-beneficiary of a CalOptima program.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a ~~Member's~~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.
Practitioner	A licensed independent 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), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing ~~Covered Services~~covered services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, ~~health maintenance organization,~~ or other person or institution that furnishes ~~Covered Services~~covered services.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Term	Definition
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima QI Registered Nurse (RN) or a CalOptima QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for ~~Members~~members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima's programs.

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

PURPOSE

This policy defines the process for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Quality Improvement (QI) Department.

POLICY

A. All CalOptima departments, Practitioners, Providers, Health Networks, and Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the CalOptima Quality Improvement (QI) Department for review and investigation.

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request medical records and/or other CalOptima records as well as pertinent documentation from Providers, as needed.

D. CalOptima's Chief Medical Officer (CMO) or Designee shall refer PQI cases to the CalOptima Credentialing and Peer Review Committee (CPRC) for further evaluation and action, pursuant to the CalOptima Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and HDO PQI data every six (6) months to identify emerging patterns. This data shall be reviewed by the CMO or Designee who shall report any issues and/or emerging patterns to the CalOptima CPRC for further evaluation and action, as necessary.

F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima CPRC.

G. The CPRC shall report a summary of trends and activities to the CalOptima Quality Improvement Committee (QIC) and to the Board of Directors' Quality Assurance Committee (QAC).

H. CalOptima shall maintain confidentiality of quality improvement case review information, in accordance this Policy.

PROCEDURE

Back to Agenda Back to Item

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and HDOs may identify and refer a PQI to CalOptima's QI Department.

2. A PQI may be referred from an internal CalOptima department, including but not limited to, Grievance & Appeals Resolution Services (GARS), Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management (UM), Case Management and Compliance.

3. Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

    a. Any entity referring a PQI case, shall identify if the Member chooses to remain anonymous.

4. A QI Nurse shall perform an initial clinical review within three (3) business days and determine:

    a. If the case is a Quality of Care (QOC) or Quality of Service (QOS) based on the initial information received; and

    b. If the Member has any urgent clinical issues, care coordination will be provided by the QI Nurse.

B. Process, Review and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima PQI team and documented in CalOptima's care management system.

    a. The CalOptima PQI team shall send an acknowledgement letter to the Member.

    b. If the Member chooses to remain anonymous, the case will be flagged as confidential and no acknowledgement letter will be sent to the Member.

    c. If the case was not referred by a Member or a Member's representative, no acknowledgement letter will be sent to the Member.

    d. The QI nurse shall request pertinent medical records and a response to the Member's complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or HDO(s) that rendered medical services or were involved in rendering the medical service(s), as needed. A Provider, Practitioner, Health Network, or HDO shall submit such records and response to the CalOptima QI Department within fourteen (14) calendar days after receipt of the request.

        i. If a Provider, Practitioner, Health Network, or HDO fails to respond within the required timeframe:

            a) The CalOptima QI Department shall follow-up with a minimum of three (3) attempts within thirty (30) business days to obtain the requested information.

            b) CalOptima may request a written and signed explanation for any delay in submitting records or responding to a request for a case review. This document shall become a permanent part of the review record.

            c) If there is no reasonable or acceptable explanation provided by the Provider, Practitioner, Health Network, or HDO, or if the delay continues, CalOptima's QI Department, in

consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of Member, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

2. CalOptima's QI Department may deem it appropriate to deploy CalOptima's copying vendor to copy and provide medical records.

3. CalOptima's QI Department shall target to complete its review upon the receipt of the case review response, medical records, and/or other supporting documentation, within one hundred twenty (120) calendar days.

4. If the case is determined by the QI Nurse to be QOS, the case shall be closed, and a resolution letter will be sent by the PQI team.

   a. If the case was referred by an internal CalOptima Department, notification of the QOS determination will be communicated to the referring department for educational purposes.

   b. The CalOptima PQI team shall send a resolution letter to the Member.

   c. If the Member chooses to remain anonymous, the case will be flagged as confidential and no resolution letter will be sent to the Member.

   d. If the case was not referred by a Member or a Member's representative, no resolution letter will be sent to the Member.

5. If the case is determined by the QI Nurse to be QOC, findings will be summarized for evaluation by the CalOptima Medical Director.

6. CalOptima Medical Director shall review with QOC case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the QOC case that reflects the severity of the outcome.

Outcome Score	Description of Outcome Score
0	No quality of care or quality of service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
H1	Potential clinical care issue with or without an adverse outcome which occurs in a hospital.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.

Outcome Score	Description of Outcome Score
HDS	Healthcare delivery system issue with or without an adverse outcome.

7. CalOptima shall utilize an external review entity if a second opinion is determined to be needed by a Medical Director.

8. If the CalOptima Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

9. If the CalOptima Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Medical Director or be presented to the CalOptima CPRC for recommendation(s).

    a. Higher severity cases will be presented to CPRC for discussion and recommendation of action.

    b. Other cases may be presented to CPRC upon Medical Director's discretion.

10. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC may recommend further action.

    a. A corrective action from the specific CalOptima department, Health Network, HDO, Practitioner, or Provider;

    b. Require the Practitioner, Provider, Health Network, HDO, or CalOptima department to perform additional educational training; or

    c. Require other appropriate action(s) as recommended by the CPRC.

11. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, HDO, Practitioner, Provider, or CalOptima Department.

12. Once the review process is completed, a resolution letter will be sent to the Health Network, the Provider and the Member, if the case was member-generated and not a confidential case.

C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC:

    a. Practitioners, Providers, and HDOs whose PQI rate is greater than practitioner, provider or HDO specialty;

    b. Open and closed cases; and

    c. Severity levels and categories of issues.

2. The QI Department shall submit all case findings and recommended actions to the CalOptima CPRC.

3. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

4. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the Quality Improvement Committee (QIC) on a quarterly basis.

5. Additionally, the CalOptima CMO, his or her Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIC to the CalOptima Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima QI Plan.

6. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

7. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

8. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network.

ATTACHMENT(S)

A. Medical Records Request Form
B. Potential QOC Issue Request for Information Template
C. Health Network Resolution Letter
D. Member Resolution Letter (Medi-Cal)
E. Member Resolution Letter (OneCare)
F. Member Resolution Letter (OneCare Connect)
G. Member Acknowledgement Letter (Medi-Cal)
H. Member Acknowledgement Letter (OneCare)
I. Member Acknowledgement Letter(OneCare Connect)
J. Provider Resolution Letter

REFERENCE(S)

A. California Business and Professions Code, §§805 and 1000-1
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
D. CalOptima Three-way Agreement with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Policy GG.1615A: Corrective Action Plan for Practitioners
F. CalOptima Quality Improvement Plan
G. Title 22, California Code of Regulations (C.C.R), §51051
H. Title 28, California Code of Regulations (C.C.R), §1300.85.1
I. Title 42, Code of Federal Regulations (C.F.R), §422.152(a)(3), (c)(2), and (d)
J. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/23/2015	Department of Health Care Services (DHCS)
03/28/2016	Department of Health Care Services (DHCS)

BOARD ACTION(S)

None to Date

REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

GLOSSARY

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 Committee (QIC).
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. For the purposes of this policy, a designee acting on behalf of the CalOptima Chief Medical Officer (CMO) shall be a CalOptima Medical Director.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), 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.
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Member	An enrollee-beneficiary of a CalOptima program.
Potential Quality Issue (PQI)	For the purposes of this policy, means 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.
Practitioner	A licensed independent 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), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes covered services.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Term	Definition
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima QI Registered Nurse (RN) or a CalOptima QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima's programs.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:** (Intake Staff), QI Program Assistant
Fax:	**Fax:**
Phone:	**Phone:** ~~657-900-1122~~(Phone)

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Member Name:	
DOB:	
CIN:	
Date(s) of Service:	
Case #:	

Dear Medical Records/Health Information Management~~,~~:

We are in the process of reviewing professional services rendered for the CalOptima member indicated above. Please submit ~~to my personal attention~~ a copy of the following reports **to my attention**:

❒ Discharge Summary
❒ Consultation Reports
❒ Medication Records
❒ Laboratory Reports
❒ Microbiology Reports
❒ Admission History & Physical
❒ Operative and Procedure Reports
❒ X-~~R~~ray/Diagnostic/Radiology Imaging Reports
❒ Emergency Room Medical Records
❒ (~~UserContent.~~ Other Reports)
~~❒ (UserContent. Other Reports)~~

The authorization to release such information is granted by Title 22, California Code of Regulations, Section 51009. All records shall be held confidential in accordance with California law. Please address your **"CONFIDENTIAL"** response via or by mail to:

CalOptima
Quality Improvement Department
~~Attention: NURSE'S NAME~~
505 City Parkway West~~,~~
Orange, CA 92868

Medi-Cal CalOptima
A Public Agency
Better. Together.

CalOptima
A Public Agency
Better. Together.

~~Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

I appreciate y~~Y~~our prompt attention to this matter by (Date) ~~will be appreciated~~. ~~-~~ Should you have any questions regarding this request, please ~~feel free to~~ contact me at ~~-~~**NURSE'S PHONE**.

Sincerely,

NURSE'S NAME
QI Nurse Specialist
Quality Improvement

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:** (Intake Staff), QI Program Assistant
Fax:	**Fax:**
Phone:	**Phone:** (Phone)

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Member Name: _____
DOB: _____
CIN: _____
Date(s) of Service: _____
Case #: _____

Dear Medical Records/Health Information Management:

We are in the process of reviewing professional services rendered for the CalOptima member indicated above. Please submit a copy of the following reports **to my attention**:

❒ Discharge Summary
❒ Consultation Reports
❒ Medication Records
❒ Laboratory Reports
❒ Microbiology Reports
❒ Admission History & Physical
❒ Operative and Procedure Reports
❒ X-ray/Diagnostic/Radiology Imaging Reports
❒ Emergency Room Medical Records
❒ (Other Reports)

The authorization to release such information is granted by Title 22, California Code of Regulations, Section 51009. All records shall be held confidential in accordance with California law. Please address your **"CONFIDENTIAL"** response via or by mail to:

CalOptima
Quality Improvement Department
505 City Parkway West
Orange, CA 92868

I appreciate your prompt attention to this matter by (Date). Should you have any questions regarding this request, please contact me at **NURSE'S PHONE.**

Sincerely,

NURSE'S NAME
QI Nurse Specialist
Quality Improvement

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

CONFIDENTIALITY WARNING: Information contained in this FAX is CONFIDENTIAL. This is intended for the use of the individual or entity named above. If the reader of this FAX message is not the intended recipient, the employee, or agent responsible to deliver it to the intended recipient, you are hereby on notice that you are in possession of confidential information. Any unauthorized distribution, copying, or dissemination of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify CalOptima by telephone toll-free at **888-587-8088** and/or return this fax message to the following fax number **657-900-1615**.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:**
Fax:	**Fax:**
Phone:	**Phone:**

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Potential Quality of Care Issue / Request for Information

1. Please submit the information requested by **DUE DATE**. If the deadline is missed, CalOptima may have to resolve the complaint without the benefit of your ~~recommendation~~information and/or response.
2. **Type of Complaint**: ❒ Quality of Care issue filed by the member
   ❒ Quality of Care issue filed by the family member
   ❒ Clinical issue filed by CalOptima staff
3. **Member Name:** **Case Number:**
   DOB: **CIN:**

   Provider/Facility Name:
   DOS:
4. **Medical Records Requested:**
   ❒ Provider Notes ❒ Problem List
   ❒ Medication List ❒ Labs
   ❒ OTHER ❒ Diagnostic Reports

Dear Provider:

In order to ensure a balanced review, your input is vital. At this time, ~~the~~ CalOptima's Quality Improvement ~~D~~department is requesting a **written response** from your office regarding the member's concerns. ~~Note, that these concerns are not reported to the California Medical Board.~~

COMPLAINT

The nurse assigned to this case is **NURSE'S NAME**. For **clinical questions** regarding the response or records, please call the nurse at **NURSE'S PHONE**. For all other inquiries, please ~~refer to the~~ contact the sender at the ~~number~~ phone number listed at the top of the fax.

~~.Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

~~Thank you for your prompt attention to this request.~~

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

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FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:**
Fax:	**Fax:**
Phone:	**Phone:**

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Potential Quality of Care Issue / Request for Information

1. Please submit the information requested by **DUE DATE**. If the deadline is missed, CalOptima may have to resolve the complaint without the benefit of your information and/or response.

2. **Type of Complaint**:
   ❒ Quality of Care issue filed by the member
   ❒ Quality of Care issue filed by the family member
   ❒ Clinical issue filed by CalOptima staff

3. **Member Name:** **Case Number:**
   DOB: **CIN:**

   Provider/Facility Name:
   DOS:

4. **Medical Records Requested:**
   ❒ Provider Notes ❒ Problem List
   ❒ Medication List ❒ Labs
   ❒ OTHER ❒ Diagnostic Reports

Dear Provider:

In order to ensure a balanced review, your input is vital. At this time, CalOptima's Quality Improvement department is requesting a **written response** from your office regarding the member's concerns.
COMPLAINT

The nurse assigned to this case is **NURSE'S NAME**. For **clinical questions** regarding the response or records, please call the nurse at **NURSE'S PHONE**. For all other inquiries, please contact the sender at the phone number listed at the top of the fax.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

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Quality Improvement Department
Potential Quality of Care Issue

DATE

Peer Review Conclusion

Dear HEALTH NETWORK:,

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. According to the documentation received, the committee reviewed and closed this case on DATE and ~~leveled it~~assigned an outcome score of ~~at~~ SEVERITY CODE – SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Date Complaint Ssent to HN:
Case Number:
Name of Provider:
Summary of Complaint: COMPLAINT CATEGORY-COMPLAINT SUBCATEGORY
Final Determination: RESOLUTION SUBCATEGORY
Reviewed by: MEDICAL DIRECTOR
Confidential Case*: ❒ Yes | ❒ No

Please ~~feel free to~~ contact me if you have any further questions at ~~(657) 900-1122~~**(Phone Number)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means

that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.
~~S.Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

Sincerely,

(Name)~~Laura Guest, RN, ANP Supervisor~~(TITLE), Quality Improvement
~~(657) 900-1122~~(Phone #)
~~lguest@caloptima.org~~(E-mail)

*Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

Quality Improvement Department
Potential Quality of Care Issue

DATE

Peer Review Conclusion

Dear HEALTH NETWORK:

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. According to the documentation received, the committee reviewed and closed this case on DATE and assigned an outcome score of SEVERITY CODE — SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Date Complaint Sent to HN:
Case Number:
Name of Provider:
Summary of Complaint: COMPLAINT CATEGORY-COMPLAINT SUBCATEGORY
Final Determination: RESOLUTION SUBCATEGORY
Reviewed by: MEDICAL DIRECTOR
Confidential Case*: ❒ Yes | ❒ No

Please contact me if you have any further questions at **(Phone Number)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

Sincerely,

(Name)
(TITLE), Quality Improvement

*Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

DATE

MEMBER NAME
ADDRESS
CITY, STATE ZIP

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear Mr./Ms. MEMBER NAME,

On DATE OF INCIDENT, CalOptima received your complaint about the care or services you received. CalOptima and its contracted health network and providers ~~medical groups~~ make every effort to provide the highest quality health care services to our members. CalOptima regrets not meeting your needs and apologizes for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,
Quality Improvement

(714) 246-8400

MM_16_24

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

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NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact CalOptima between 8:00 a.m. – 5:30 p.m. by calling 1-714-246-8500. Or, if you cannot hear or speak well, please call TYY/TDD 1-800-735-2929.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8:00 a.m. and 5:30 p.m. by calling 1-888-587-8088. Or, if you cannot hear or speak well, please call 1-800-735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868
- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.

- Electronically: Visit CalOptima's website at www.caloptima.org.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

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LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-587-8088 (TTY: 1-800-735-2929).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-587-8088 (TTY: 1-800-735-2929).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-888-587-8088 (TTY: 1-800-735-2929).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung ikaw ay nagsasalita sa wikang Tagalog, may mga serbisyo sa pananalita na makakatulong sa iyo na maari mong gamitin nang walang bayad. Tumawag sa 1-888-587-8088 (TTY: 1-800-735-2929).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-587-8088 (TTY: 1-800-735-2929)번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您说繁體中文，您可以免費獲得語言援助服務。請致電 1-888-587-8088（TTY：1-800-735-2929）。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-587-8088 (телетайп: 1-800-735-2929).

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-888-587-8088** (TTY: **1-800-735-2929**) تماس بگیرید.

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

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日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-587-8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEBTOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, pab dawb rau koj. Hu rau 1-888-587-8088 (TTY: 1-800-735-2929).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-888-587-8088.**

हिंदी (Hindi)

ध्यान दें : यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-587-8088 (TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)

ข้อควรคำนึง: ถ้าหากคุณพูดภาษาไทย, คุณสามารถใช้บริการความช่วยเหลือทางภาษา, โดยไม่เสียค่าใช้จ่ายใด ๆ ได้โดย, โทร 1-888-587-8088 (TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)
ចំណុចសំខាន់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយផ្នែកភាសាគឺមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໄດ້. ໂທຫາ 1-888-587-8088 (TTY: 1-800-735-2929).

MCAL MM-17-77_DHCS Approved 10.04.17_Updated Language Assistance Tagline

DATE

MEMBER NAME
ADDRESS
CITY, STATE ZIP

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear Mr./Ms. MEMBER NAME,

On DATE OF INCIDENT, CalOptima received your complaint about the care or services you received. CalOptima and its contracted health network and providers make every effort to provide the highest quality health care services to our members. CalOptima regrets not meeting your needs and apologizes for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,
Quality Improvement
(714) 246-8400

MM_16_24

NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact CalOptima between 8:00 a.m. – 5:30 p.m. by calling 1-714-246-8500. Or, if you cannot hear or speak well, please call TYY/TDD 1-800-735-2929.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8:00 a.m. and 5:30 p.m. by calling 1-888-587-8088. Or, if you cannot hear or speak well, please call 1-800-735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868
- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.

- Electronically: Visit CalOptima's website at www.caloptima.org.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

LANGUAGE ASSISTANCE

English
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Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-587-8088 (TTY: 1-800-735-2929).

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CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-888-587-8088 (TTY: 1-800-735-2929).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung ikaw ay nagsasalita sa wikang Tagalog, may mga serbisyo sa pananalita na makakatulong sa iyo na maari mong gamitin nang walang bayad. Tumawag sa 1-888-587-8088 (TTY: 1-800-735-2929).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-587-8088 (TTY: 1-800-735-2929)번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您说繁體中文，您可以免費獲得語言援助服務。請致電 1-888-587-8088（TTY：1-800-735-2929）。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929):

Русский (Russian)
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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-888-587-8088** (TTY: **1-800-735-2929**) تماس بگیرید.

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

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1-888-587-8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEBTOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, pab dawb rau koj. Hu rau 1-888-587-8088 (TTY: 1-800-735-2929).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-888-587-8088.**

हिंदी (Hindi)

ध्यान दें : यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-587-8088 (TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)

ข้อควรคำนึง: ถ้าหากคุณพูดภาษาไทย, คุณสามารถใช้บริการความช่วยเหลือทางภาษา, โดยไม่เสียค่าใช้จ่ายใด ๆ ได้โดย, โทร 1-888-587-8088 (TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)
ចំណុចសំខាន់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយផ្នែកភាសាគឺមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໄດ້. ໂທຫາ 1-888-587-8088 (TTY: 1-800-735-2929).

MCAL MM-17-77_DHCS Approved 10.04.17_Updated Language Assistance Tagline

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear ~~<Member Name>~~Mr./Ms. ~~:~~,

On (Insert Date)~~<Date>~~, OneCare (HMO SNP) received your complaint about the care or services you received. OneCare and its contracted health networks and providers make every effort to provide the highest quality health care services to our members. OneCare regrets not meeting your needs and ~~apologizes~~ is sorry for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,

Quality Improvement
1-~~(~~714~~)~~ 246-8400

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. ~~TDD/~~TTY users can call **1-800-735-2929**.

H5433_GA17_1_NM

LANGUAGE ASSISTANCE

English ATTENTION: If you speak another language, language assistance services, free of charge, are available to you.– Call ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.– Llame al ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.– Gọi số ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Tagalog (Tagalog – Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.– Tumawag sa ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.– ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**)번으로 전화해 주십시오.

繁體中文 (Chinese) 注意： 如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 ~~1-877-412-2734~~ **1-877-412-2734** （TTY：~~1-800-735-2929~~**1-800-735-2929**）。

Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք ~~1-877-412-2734~~ **1-877-412-2734** (TTY (հեռատիպ)՝ ~~1-800-735-2929~~**1-800-735-2929**):

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.– Звоните ~~1-877-412-2734~~ **1-877-412-2734** (телетайп: ~~1-800-735-2929~~**1-800-735-2929**).

فارسی (Farsi)
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OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

日本語 (Japanese) 注意事項： 日本語を話される場合、
無料の言語支援をご利用いただけます。 ~~1-877-412-2734~~ **1-877-412-2734** （TTY: ~~1-800-735-29291~~**1-800-735-2929**） まで、 お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.– Hu rau ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-29291~~**1-800-735-2929**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-29291~~**1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-412-2734
(رقم هاتف الصم والبكم: 1-800-735-2929).

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-29291~~**1-800-735-2929**) पर कॉल करें।

ภาษาไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-29291~~**1-800-735-2929**).

ខ្មែរ (Cambodian) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-29291~~**1-800-735-2929**)។

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.– ໂທຣ ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-29291~~**1-800-735-2929**).

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
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Dear :

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H5433_GA17_1_NM

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Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-412-2734** (TTY: **1-800-735-2929**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-877-412-2734** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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(رقم هاتف الصم والبكم: 1-800-735-2929).

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Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear ~~Mr./Mrs. <Member Name>:~~,

On (Insert Date)~~<Date>~~, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) received your complaint about the care or services you ~~received~~were given. OneCare Connect and its contracted health networks and providers make every effort to provide the highest quality health care services to our members. OneCare Connect regrets not meeting your needs and ~~apologizes~~ is sorry for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,

Quality Improvement
~~(~~1-714~~)~~ -246-8400

H8016_GA17_1C Approved (6/20/2017)

Notice of Nondiscrimination

OneCare Connect Cal MediConnect Plan (Medicare- Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare Connect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare Connect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ✓ Qualified sign language interpreters
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  - ✓ Information written in other languages

If you need these services, contact OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week. ~~TDD/~~TTY users can call **1-800-735-2929**. If you believe that OneCare Connect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance & Appeals
505 City Parkway West, Orange, CA 92868
Telephone number: 1-714-246-8554
TTY number: **1-800-735-2929**
Fax: 1-714-246-8562
Email: grievancemailbox@caloptima.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Grievance & Appeals Resolution Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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LANGUAGE ASSISTANCE

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Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

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Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

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Quality Improvement
1-714-246-8400

H8016_GA17_1C Approved (6/20/2017)

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Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

Thank you for letting us know about your complaint telling us that you were not satisfied with part of CalOptima's program on [date]. CalOptima takes your complaint seriously, and we will launch an investigation right away. We apologize for any problem this may have caused you.

CalOptima and its contracted health networks and providers work hard to provide the highest quality health care services to our members.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

If you or your family would like this letter translated into a different language, please call the CalOptima Customer Service department toll-free at **1-888-587-8088**. TTY users can call toll free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Quality Improvement

Enclosures:
Language Assistance Taglines
Nondiscrimination Notice

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

Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500

Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

Thank you for letting us know about your complaint telling us that you were not satisfied with part of the OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Plan on <date>. OneCare Connect takes your complaint seriously, and we will launch an investigation right away. We are sorry for any problem this may have caused you.

OneCare Connect and its contracted health networks and providers work hard to provide the highest quality health care services to our members.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

If you or your family would like this letter translated into a different language, please call OneCare Connect Customer Service toll-free 7 days a week, 24 hours a day, at **1-855-705-8823**. TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Quality Improvement

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TTY users can call **1-800-735-2929**.

LANGUAGE ASSISTANCE

English ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم **1-855-705-8823** (TTY: **1-800-735-2929**).

Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear : Mr./Mrs.

Thank you for letting us know about your complaint in which you expressed sharedtelling us that you were not satisfied dissatisfaction with part of the OneCare (HMO SNP) program on (Insert Date). OneCare takes your complaint seriously, and we will immediately launch an investigation at onceright away. We apologize are sorry for any problem this may have caused you.

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If you or your family wants would like this letter translated into a different language, please cCall OneCare Customer Service toll-free 7 days a week, 24 hours a day, at1-877-412-2734 1-877-412-2734. TTY/TDDTY users can call toll-free at 1-800-735-29291-800-735-2929. We have staff who speak your language.

Sincerely,

Quality Improvement

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age,

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Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
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Dear :

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Quality Improvement Department
Potential Quality of Care Issue

DATE

PROVIDER
ADDRESS
CITY, STATE ZIP CODE

Peer Review Conclusion

Dear PROVIDER~~,~~:

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. ~~–~~According to the documentation received, the committee reviewed and closed this case on DATE and ~~leveled it at~~assigned an outcome score of SEVERITY CODE and SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Case Number:
Date of Incident:
Name of Health Network:
Summary of Complaint: COMPLAINT CATEGORY ~~–~~ COMPLAINT SUBCATEGORY)
Final Action:
Confidential Case*: ☐ Yes | ☐ No

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.
~~,S.Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and~~

~~Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

Please contact QI ~~Supervisor~~(Title) ~~Laura Guest, RN, ANP~~(Nname), ~~QI Supervisor,~~ if you have any questions at ~~(657) 900-1122~~(Phone). Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Sincerely,

~~Miles Masatsugu, M.D.~~(Name)
Medical Director
qualityofcare@caloptima.org

* Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

Quality Improvement Department
Potential Quality of Care Issue

DATE

PROVIDER
ADDRESS
CITY, STATE ZIP CODE

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CIN #: **DOB:**
Case Number:
Date of Incident:
Name of Health Network:
Summary of Complaint: COMPLAINT CATEGORY — COMPLAINT SUBCATEGORY)
Final Action:
Confidential Case*: ☐ Yes | ☐ No

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Please contact QI **(Title) (Name)**, if you have any questions at **(Phone)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Sincerely,

(Name)
Medical Director
qualityofcare@caloptima.org

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Policy: GG.1615Δ
Title: **Corrective Action Plan for Practitioners**
Department: Medical Management
Section: Quality Improvement

CEO Approval:

Effective Date: 04/01/1996
Revised Date: TBD

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE
☐ Administrative

I. PURPOSE

~~To define~~This policy defines the appropriate corrective action process that CalOptima shall use for Practitioners, including routine monitoring, investigation, and ~~education,~~ corrective action~~, summary suspension, automatic suspension,~~ related to his or ~~limitation or termination~~her clinical practice.

II. POLICY

~~A. CalOptima has the responsibility for conducting any investigation, and initiating corrective action against a Practitioner to ensure the safety of CalOptima Members.~~

~~B. CalOptima, a Health Network (HN), or a Physician Medical Group (PMG) shall suspend, restrict, or terminate a Practitioner's participation, in accordance with the terms and conditions of this policy.~~

~~C. CalOptima, HN or PMG shall notify a Practitioner, in writing, of a decision, which shall include the reasons, standards, and data used to make such decision, to suspend, restrict, or terminate the Practitioner.~~

~~D. CalOptima, the HN, or PMG shall notify a Practitioner, in writing, at least sixty (60) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.~~

~~E. CalOptima shall notify the National Practitioner Data Bank (NPDB), the Medical Board of California (MBOC), the Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), and any other applicable regulatory body, of corrective action when required to do so by law.~~

~~A. Routine Monitoring and Education~~

~~1. Responsibility~~

~~F.~~A. The Quality Improvement Committee (QIC) oversees CalOptima's quality improvement activities. CalOptima's Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are responsible for the ~~quality~~Quality of ~~care~~Care and service provided by CalOptima.

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~~G.~~B. ~~It shall be the responsibility of the~~The CalOptima's CMO or his or her ~~designee~~physician Designee working through, as appropriate, such standing or ad hoc peer review committee as CalOptima may from time to time establish, ~~to~~shall design and implement an effective quality program for the following purposes:

1. To monitor and assess the quality of professional practice of all Practitioners; and

2. To promote high quality of practice by providing education and counseling~~:~~, issuing letters of admonition, warning or censure, as necessary; and requiring routine monitoring when deemed appropriate by CalOptima or ~~its peer review committees.~~the CalOptima Credentialing and Peer Review Committee (CPRC).

~~3.Require routine monitoring when deemed appropriate by CalOptima or its peer review body.~~

~~2. Procedure~~

~~a. Review and Studies~~

C. ~~CalOptima and its QIC,~~CalOptima may conduct an investigation and initiate corrective action against a Practitioner in any Health Network, including to investigate Member complaints and ensure the safety of CalOptima Members.

D. CalOptima shall take corrective action, for a non-medical and ~~Credentialing~~medical disciplinary cause or reason, in accordance with the terms and conditions of this Policy.

E. Corrective actions may be imposed based on administrative or clinical findings. Certain investigations and corrective actions (*e.g.*, restriction of members or services) taken on the basis of a medical disciplinary cause or reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB).

F. CalOptima shall implement any suspension or restriction imposed on a Practitioner for a medical disciplinary cause or reason in accordance with CalOptima Policy GG.1658

G. CalOptima shall notify a Practitioner, in writing, in accordance with that Practitioner's contract, but in no case less than sixty (60) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.

H. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners with a corrective action process when the Health Network takes or proposes action including routine monitoring, corrective action, or investigation related to a Practitioner's clinical practice.

III. PROCEDURE

A. Routine Monitoring

1. All Practitioners, regardless of status, shall be subject to ~~Peer Review Committees (CCPRC)~~routine monitoring.

~~1.~~2. The Quality Improvement (QI) Department shall conduct regular patient ~~care~~ reviews and studies of practice consistent with CalOptima general quality assessment and improvement

activities and shall investigate Potential Quality Issues and complaints and ~~unusual practice-related~~Quality of Care incidents~~. The QIC~~ in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process, and shall ~~meet at a minimum on quarterly basis~~report to ~~review all cases presented and reviewed at~~ the ~~CCPRC which meets a minimum of four (4) times a year~~CPRC the results of investigations deemed a Quality of Care issue.

3. The QI Department shall routinely monitor, trend, and analyze Practitioner Potential Quality Issues (PQI) cases and Grievances.

~~b. If Informal Counseling and Education~~

any issues or trends emerge with any Practitioner during the monitoring process, and

~~2.~~4. ~~In order~~ to assist Practitioners to conform their conduct or ~~practitioner~~Practitioner practice to the standards of CalOptima, the CMO or his or her ~~designee~~physician Designee may issue informal comments or suggestions, either orally or in writing~~.~~ or take corrective action as outlined in Section III.C. of this Policy.

~~3.~~5. ~~Such~~Informal comments or suggestions shall be confidential~~,~~ and may be issued by the CMO or his or her ~~designee~~physician Designee with or without prior discussion with the recipient, and with or without consultation with any CalOptima committee.

~~4.~~6. Such comments or suggestions shall not constitute a restriction of practice prerogatives, and shall not be considered to be ~~"~~a "corrective action" as that term is used in Section III.~~B of this policy, and shall not give rise to hearing rights under the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners~~C.

~~c. Notification of Concerns: Routine Monitoring~~

~~a. Following discussion of identified concerns with any Practitioner, the QIC and CCPRC, as applicable, may recommend that the CMO or his or her designee issue a letter of admonition, warning or censure, or to require such Practitioner to be subject to routine monitoring for such time as may appear reasonable.~~

~~b. All Practitioners, regardless of status, shall be subject to potential routine monitoring. The discussion of such actions with individual Practitioners shall be informal. Such action shall not constitute a restriction of practice prerogatives and shall not be considered to be "corrective action," as that term is used in Section III.B of this policy, and shall not give rise to hearing rights under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.~~

~~5.~~7. The term "routine monitoring," as used in this section, shall mean review of a Practitioner's practice and may include activities for which the Practitioner's only obligation is to provide reasonable advance notice to any CalOptima committee or representative of certain patient care procedures or other patient care activity.

B. Corrective Action for Medical Disciplinary or Non-Medical Disciplinary Cause or Reason

1. Criteria for Initiation

a. Any person may provide information to the CMO, the QIC or ~~CCPRC~~CPRC about the conduct, performance, or competence of any CalOptima ~~Direct~~ Practitioner.

b. A request for an investigation or action against a CalOptima Practitioner may be initiated by the CalOptima CMO, the CEO, the QIC or ~~CCPRC~~CPRC, or the Quality Improvement Department when reliable information indicates that the Practitioner ~~may have~~has exhibited acts, demeanor, or conduct reasonably likely to be:

i. Detrimental to patient safety or to the delivery of quality patient care;

ii. Unethical;

iii. Contrary to CalOptima policies, rules, and regulations;

iv. Contrary to his/her CalOptima agreement (if applicable), or,

v. Below applicable CalOptima Practitioner standards.

2. Initiation

a. A request for an investigation must be submitted to the CalOptima CPRC by a person or committee ~~listed above, and~~, such as CMO, the CEO, or the QIC, and must be supported by reference to specific activities or conduct alleged to be detrimental to patient safety or to the delivery of quality patient care, unethical, contrary to CalOptima policies or the CalOptima ~~agreement~~contract (if applicable), or below CalOptima Practitioner standards. If the CPRC initiates the investigation, it shall record the reasons for the investigation in committee meeting minutes.

3. Investigation

a. If the CalOptima CPRC concludes that an investigation is warranted ~~with regard to a Practitioner~~, it shall direct an investigation to be undertaken.

i. The CPRC may conduct the investigation ~~itself,~~ or may assign ~~the task~~non-medical/administrative investigations to another ~~individual~~CalOptima Committee or ~~body.~~ Department.

ii. If the investigation is delegated to a body or individual other than the CPRC, such body or individual shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the CPRC as soon as possible. The report may include recommendations for appropriate corrective action.

iii. If, during the investigation, a reportable corrective action for a Medical Disciplinary Cause or Reason is contemplated, the Practitioner shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual or body deems appropriate.

iv. The individual or body investigating the matter may, but is not obligated to, interview the persons involved. Such interviews shall not constitute a "hearing," ~~as that~~in the manner the term is used in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioner, nor shall any of the procedural rules for hearings apply.

v. Despite the status of any investigation, the CPRC ~~at all times~~always retains authority and discretion to take whatever action may be warranted by the circumstances,

including summary termination of participation, termination of the investigative process, or other action.

vi. Investigations shall be completed within sixty (60) calendar days unless otherwise directed by the CPRC.

b. In the event of a formal investigation during the credentialing (or recredentialing) process and the provider withdraws his or her application, CalOptima shall determine if an 805 report and/or report to the NPDB is required in accordance with CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

4. Corrective Action

a. Corrective action can be taken as a result of issues found through routine monitoring and subsequent PQI investigations in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review process, or as a result of issues found during formal investigations.

b. The corrective action ~~As soon as practical after~~may be for a non-medical/administrative reason or a medical, disciplinary cause or reason, and if for a medical disciplinary cause or reason may result in a reportable action.

~~a.~~c. At the conclusion of the investigation, the CPRC shall determine whether to recommend any corrective action, and if so, whether the corrective action recommended is for a "non-medical or medical disciplinary cause or reason." ~~Actions which the CPRC may recommend shall include, without limitation, the following:~~, and will determine if action is reportable pursuant to CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

~~i. Determining that no corrective action should be taken;~~

d. Corrective action for a Non-Medical Disciplinary Cause or Reason

i. If a corrective action is recommended for a "non-medical disciplinary cause or reason" such as customer service-related issues or delays in responding to medical records requests, which the CPRC may take, shall include, without limitation, the following:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant;

b) Sending the Practitioner a community best practice letter;

c) Recommending Practitioner education;

d) Recommending office staff training;

e) Requesting a written Corrective Action Plan (CAP), with appropriate time frames for correction, from the Practitioner demonstrating how the issue will be prevented in the future;

f) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action; or

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g) Taking other actions deemed appropriate under the circumstances, including, but not limited to, closing physician panels or freezing specialist referrals.

ii. A corrective action for a "non-medical disciplinary cause or reason" shall not constitute a restriction of practice prerogatives, shall not be considered to be a reportable corrective action for a "medical disciplinary cause or reason" as that term is used in Section III.C.4.e. of this Policy, and shall not give rise to hearing rights as outlined in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

iii. If no improvement is found after the "non-medical disciplinary" corrective action is taken within the specified time frame, and the issue addressed in the action is a contractual requirement, the CPRC may escalate the case to CalOptima's Office of Compliance for further action.

e. Corrective action for a "Medical Disciplinary Cause or Reason"

i. If a corrective action is recommended for a "medical disciplinary cause or reason," CPRC may recommend one or more of the following actions:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

b) Sending the Practitioner a community best practice letter.

c) Recommending Practitioner education.

d) Recommending a written Corrective Action Plan from the Practitioner clearly demonstrating how the issue will be prevented in the future.

~~a)~~e) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her ~~designee~~physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action.

f) Recommending ~~the imposition of terms of probation~~ mandatory participation in: UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or ~~special limitation upon~~ a Physician Enhancement Program (PEP).

~~b)a)~~Imposing, or the Practitioner's ~~participation, including, without limitation, requirements for mandatory consultation or monitoring~~voluntarily acceptance of, a~~;~~

g) ~~Recommending reduction, modification, limitation,~~ suspension~~,~~ of or ~~termination of~~ restrictions on a Practitioner's provision of services to CalOptima Members.

h) Terminating the practitioner's participation~~;~~ in CalOptima's network.

ii. Actions taken for a "Medical Disciplinary Cause or Reason" may require reporting to the California Medical Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Policy GG.1657Δ: Medical Board of California and the National

Practitioner Data Bank (NPDB) Reporting. Reporting under that policy may also be required upon resignation or a leave of absence by a Practitioner from participation in CalOptima programs after notice of an investigation initiated for a "Medical or Disciplinary Cause or Reason."

~~ii. Taking other actions deemed appropriate under the circumstances.~~

iii. For an action that must be reportable under Section 805/809.1 hearing eligible, as described in CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network, include medical disciplinary cause or reasons such as:

a) Incompetence;

b) Gross deviation from the standard of care;

c) Self-prescribing or self-administering controlled substances;

d) Abusing drugs or alcohol;

e) Repeated acts of excessive prescribing or providing controlled substances, and

f) Sexual misconduct with a patient.

iv. If the investigation concludes there is nothing of merit, no corrective action will be taken.

C. Subsequent Actions

~~a.~~ If the CPRC recommends any ~~reportable~~ corrective action which would entitle a Practitioner to request a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, the CPRC shall give the Practitioner written notice of its recommendation, as provided in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners~~.~~ prior to imposing such action. A copy of that notice shall be sent to the QIC for ~~information~~informational purposes only. The CPRC shall also ~~report~~ provide notice to CalOptima's Office of Compliance and to Legal Affairs.

1. ~~If the CPRC decides to impose a summary suspension, termination, or summary restriction of the Practitioner's participation, the CPRC shall provide the Practitioner with written notice at least sixty (60) calendar days prior to imposing such action.~~ The written notice shall include:

a. The reasons for the action;

b. The standards and profiling data used to evaluate the Practitioner; and

c. Information regarding the Practitioner's ~~Appeal~~appeal rights.

D. CPRC

1. Any CPRC action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIC.

2. If the CPRC does not recommend any corrective action which would entitle the CalOptima ~~Direct~~ Practitioner to a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing for Practitioners, the CPRC shall either file its report with a recommendation of no further action or take the action that is not reportable.

3. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These medical disciplinary causes or reasons covered by Section 805.01 are:

   a. Incompetence;

   b. Gross deviation from the standard of care;

   c. Self-prescribing or self-administering controlled substances;

   d. Abusing drugs or alcohol;

   e. Repeated acts of excessive prescribing or providing of controlled substances; and
   f. Sexual misconduct with a patient.

E. Action Initiation by QIC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIC may direct the CPRC to initiate investigation or disciplinary action.

2. If the CPRC fails to take action in response to that direction from the QIC, the QIC may initiate corrective action.

~~F. Summary Suspension Or Restriction~~

~~1. Criteria for Summary Suspension or Restriction~~

~~a. Whenever the failure to immediately suspend or restrict a Practitioner's practice in CalOptima may result in imminent danger to the health of any individual, the CalOptima CMO or his or her designee, the CEO, or the CPRC, or the QIC, shall have the authority to summarily suspend or restrict a contracted Practitioner's practice prerogatives.~~

~~G. Authority to Impose Summary Suspension or Restriction~~

~~a. If the CalOptima CMO or his or her designee, the CEO, the CPRC, or the QIC is not available to summarily restrict or suspend the Practitioner's participation in CalOptima, a designated member of the CPRC may immediately suspend a Practitioner's participation with CalOptima if there is imminent danger to the health of any patient, prospective patient, or to any other individual.~~

~~b. Any restriction or suspension by any of those individuals in Section III.J of this policy is subject to ratification by the CPRC. When such ratification is required, the members shall be notified of the summary suspension immediately, both orally and in writing.~~

c. If the CPRC does not ratify such a summary suspension within two (2) calendar days, excluding weekends and holidays, the summary restriction or suspension shall terminate automatically.

H. Initiation of Summary Action

a. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall immediately give oral and written notice, via certified mail, to the Practitioner and also shall notify in writing the CMO, CEO, CPRC, and QIC within five (5) calendar days after imposition of such suspension.

b. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

c. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's Members shall be promptly assigned to another Practitioner considering, where feasible, the wishes of a Member in the choice of a substitute Practitioner.

d. The written notice shall inform the Practitioner of his or her right to request that the CPRC review the suspension under Section III.B of this policy, and that the Practitioner may attend the review.

e. The CPRC may recommend further corrective action as appropriate based on information disclosed or otherwise made available to it or it may direct that an investigation be undertaken in accordance with Section III.B of this policy.

b.a. The notice of the summary suspension or restriction given to the CPRC shall constitute a request for corrective action, and the procedures set forth in Section III.B of this policy shall be followed.

f. The corrective action investigation shall be completed promptly so any hearing on the summary suspension or restriction and corrective action can be commenced within the sixty (60) day limits after a hearing on a summary suspension is requested. However, because of the summary nature of the action, reasonable efforts should be made to complete the investigation and to schedule the hearing as promptly as is feasible under the circumstances and as permitted by relevant law.

I. CalOptima CPRC Action

a. Within two (2) calendar days, excluding weekends and holidays, after such summary restriction or suspension has been imposed, a meeting of the CPRC shall be convened to review and consider the action.

b. Upon request of the Practitioner or the CPRC, the Practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the CPRC may impose. In no event shall any such meeting of the CPRC, with or without the Practitioner, constitute a "hearing" nor shall any of the procedural rules for hearings apply, nor shall either party be represented by counsel.

c. The CPRC may modify, continue, or terminate the summary restriction or suspension.

d. The CPRC shall provide the Practitioner with notice of its decision.

~~J. Procedural Rights~~

~~1. The Practitioner shall be entitled to hearings and appeals procedures pursuant to the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if the summary restriction or suspension is not promptly terminated by CPRC.~~

~~2. Any suspension that exceeds fourteen (14) days shall be reported to the Medical Board of California pursuant to the California Business and Professions Code, Section 805.~~

~~K.~~F. Automatic Termination, Suspension or Limitation

1. A Practitioner shall inform the CMO promptly, and in writing, of any change in his or her compliance including, without limitation, professional license status, eligibility to participate in any federal health care program, including Medi-Cal or Medicare, compliance with CalOptima requirements for professional liability insurance, or conviction of a felony.

2. The Practitioner also must inform the CMO pursuant to this ~~section~~Section, if he/she is listed in the ~~Medicare Sanction Activity Report; is terminated~~OIG List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) list, or ~~suspended by, or becomes ineligible for,~~the Medi-Cal ~~participation; is convicted of a felony; or ceases to comply with CalOptima requirements for professional liability insurance.~~Suspended and Ineligible Provider List).

3. In the following instances, the Practitioner's participation may be terminated, suspended, limited, restricted, or placed on probation as described, and such action shall be final, without any of the procedural rights described in ~~the~~ CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. Further, any other action required by CalOptima policies and contractual requirements with respect to the Practitioner's participation in (including through the ~~health networks~~Health Networks) shall be taken as applicable.

   a. Licensure

      i. Whenever a Practitioner's license or other legal credential authorizing practice in California is revoked, suspended, or lapses, the Practitioner's participation shall automatically be terminated as of the date such action becomes effective.

      ii. Whenever a Practitioner's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, the Practitioner's participation with shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term, at least.

      iii. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her participation status with CalOptima shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term, at least.

      iv. Whenever a Practitioner's license or other legal credential is suspended, the Practitioner's participation shall be suspended, at least for the term of the suspension.

   b. Controlled Substances

      i. Whenever a ~~CalOptima Direct~~ Practitioner's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, or has expired, the Practitioner shall

automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.

ii. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term.

c. Medicare/Medi-Cal

i. If a Practitioner is suspended or excluded from participation or otherwise becomes ineligible to participate in Federal or State health care programs including, without limitation, the Medicare or Medi-Cal program, the Practitioner's participation shall automatically be terminated as of the effective date of the sanction.

d. Conviction of a Felony

i. A Practitioner who is convicted of any felony shall immediately and automatically be suspended. Such suspension is effective on conviction and does not await the conviction becoming final.

e. Professional Liability Insurance Eligibility

i. If, for any reason, a Practitioner fails to maintain professional liability insurance as required by CalOptima, the Practitioner's participation shall automatically be suspended until the Practitioner is covered by professional liability insurance acceptable to CalOptima.

~~A Practitioner whose participation is automatically suspended or terminated shall not be entitled to the procedural rights set forth in CalOptima Policy GG.1616Δ: Fair Hearing for Practitioners, unless the suspension is reportable under California Business and Professions Code, Section 805~~

~~L. Interviews~~

~~1. An interview shall neither constitute nor be deemed a "hearing," as that term is used in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. It shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable to hearings.~~

~~2. At the Practitioner's request, CalOptima shall be required to grant the Practitioner an interview only when so specified in this policy. In all other cases where CalOptima has before it an adverse recommendation as defined in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, it may, but shall not be required to, offer the Practitioner an interview.~~

~~a. In the event an interview is granted, the Practitioner shall be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto.~~

~~b. A record of the matters discussed and findings resulting from such interview shall be made.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, Section 805
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 Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Compliance Plan
~~A.~~G. CalOptima Quality Improvement Program
~~B. CalOptima Compliance Plan~~
~~C. 2013 NCQA Standards for Credentialing~~
~~D. CalOptima Policy AA.1000: Glossary of Terms~~
~~E.~~H. CalOptima Policy GG.~~1609Δ: Credentialing and Recredentialing~~1611: Potential Quality Issue Review Process
~~F.~~I. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
~~G.~~J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~H.~~K. CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting
~~I.~~L. CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

~~Not Applicable~~
None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615Δ	CalOptima Direct Corrective Action Plan for Practitioners	
Revised	03/01/2013	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	TBD	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
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.
Credentialing and Peer Review Committee	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.
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.
Grievance	Any Complaint or dispute, other than an organization or coverage determination or late enrollment penalty determination, expressing dissatisfaction with the manner in which CalOptima, its providers or delegated entities provides health care services, or the operations, activities, or behavior, regardless of whether any remedial action can be taken.
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.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	A beneficiary enrolled in a CalOptima program.
Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing decision
Potential Quality Issue(s)	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.
Practitioner	A licensed independent 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), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

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Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

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Policy:	GG.1615Δ
Title:	**Corrective Action Plan for Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	04/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the appropriate corrective action process that CalOptima shall use for Practitioners, including routine monitoring, investigation, and corrective action related to his or her clinical practice.

II. POLICY

A. The Quality Improvement Committee (QIC) oversees CalOptima's quality improvement activities. CalOptima's Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are responsible for the Quality of Care and service provided by CalOptima.

B. The CalOptima's CMO or his or her physician Designee working through, as appropriate, such standing or ad hoc peer review committee as CalOptima may from time to time establish, shall design and implement an effective quality program for the following purposes:

1. To monitor and assess the quality of professional practice of all Practitioners; and

2. To promote high quality of practice by providing education and counseling, issuing letters of admonition, warning or censure, as necessary; and requiring routine monitoring when deemed appropriate by CalOptima or the CalOptima Credentialing and Peer Review Committee (CPRC).

C. CalOptima may conduct an investigation and initiate corrective action against a Practitioner in any Health Network, including to investigate Member complaints and ensure the safety of CalOptima Members.

D. CalOptima shall take corrective action, for a non-medical and medical disciplinary cause or reason, in accordance with the terms and conditions of this Policy.

E. Corrective actions may be imposed based on administrative or clinical findings. Certain investigations and corrective actions (*e.g.*, restriction of members or services) taken on the basis of a medical disciplinary cause or reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB).

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F. CalOptima shall implement any suspension or restriction imposed on a Practitioner for a medical disciplinary cause or reason in accordance with CalOptima Policy GG.1658

G. CalOptima shall notify a Practitioner, in writing, in accordance with that Practitioner's contract, but in no case less than sixty (60) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.

H. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners with a corrective action process when the Health Network takes or proposes action including routine monitoring, corrective action, or investigation related to a Practitioner's clinical practice.

III. PROCEDURE

A. Routine Monitoring

1. All Practitioners, regardless of status, shall be subject to routine monitoring.

2. The Quality Improvement (QI) Department shall conduct regular patient reviews and studies of practice consistent with CalOptima general quality assessment and improvement activities and shall investigate Potential Quality Issues and complaints and Quality of Care incidents in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process, and shall report to the CPRC the results of investigations deemed a Quality of Care issue.

3. The QI Department shall routinely monitor, trend, and analyze Practitioner Potential Quality Issues (PQI) cases and Grievances.

4. If any issues or trends emerge with any Practitioner during the monitoring process, and to assist Practitioners to conform their conduct or Practitioner practice to the standards of CalOptima, the CMO or his or her physician Designee may issue informal comments or suggestions, either orally or in writing or take corrective action as outlined in Section III.C. of this Policy.

5. Informal comments or suggestions shall be confidential and may be issued by the CMO or his or her physician Designee with or without prior discussion with the recipient, and with or without consultation with any CalOptima committee.

6. Such comments or suggestions shall not constitute a restriction of practice prerogatives, and shall not be considered to be a "corrective action" as that term is used in Section III.C.

7. The term "routine monitoring," as used in this section, shall mean review of a Practitioner's practice and may include activities for which the Practitioner's only obligation is to provide reasonable advance notice to any CalOptima committee or representative of certain patient care procedures or other patient care activity.

B. Corrective Action for Medical Disciplinary or Non-Medical Disciplinary Cause or Reason

1. Criteria for Initiation

a. Any person may provide information to the CMO, the QIC or CPRC about the conduct, performance, or competence of any CalOptima Practitioner.

b. A request for an investigation or action against a CalOptima Practitioner may be initiated by the CalOptima CMO, the CEO, the QIC or CPRC, or the Quality Improvement Department when reliable information indicates that the Practitioner has exhibited acts, demeanor, or conduct reasonably likely to be:

i. Detrimental to patient safety or to the delivery of quality patient care;

ii. Unethical;

iii. Contrary to CalOptima policies, rules, and regulations;

iv. Contrary to his/her CalOptima agreement (if applicable), or,

v. Below applicable CalOptima Practitioner standards.

2. Initiation

a. A request for an investigation must be submitted to the CalOptima CPRC by a person or committee, such as CMO, the CEO, or the QIC, and must be supported by reference to specific activities or conduct alleged to be detrimental to patient safety or to the delivery of quality patient care, unethical, contrary to CalOptima policies or the CalOptima contract (if applicable), or below CalOptima Practitioner standards. If the CPRC initiates the investigation, it shall record the reasons for the investigation in committee meeting minutes.

3. Investigation

a. If the CalOptima CPRC concludes that an investigation is warranted, it shall direct an investigation to be undertaken.

i. The CPRC may conduct the investigation or may assign non-medical/administrative investigations to another CalOptima Committee or Department.

ii. If the investigation is delegated to a body or individual other than the CPRC, such body or individual shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the CPRC as soon as possible. The report may include recommendations for appropriate corrective action.

iii. If, during the investigation, a reportable corrective action for a Medical Disciplinary Cause or Reason is contemplated, the Practitioner shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual or body deems appropriate.

iv. The individual or body investigating the matter may, but is not obligated to, interview the persons involved. Such interviews shall not constitute a "hearing," in the manner the term is used in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioner, nor shall any of the procedural rules for hearings apply.

v. Despite the status of any investigation, the CPRC always retains authority and discretion to take whatever action may be warranted by the circumstances, including summary termination of participation, termination of the investigative process, or other action.

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vi. Investigations shall be completed within sixty (60) calendar days unless otherwise directed by the CPRC.

b. In the event of a formal investigation during the credentialing (or recredentialing) process and the provider withdraws his or her application, CalOptima shall determine if an 805 report and/or report to the NPDB is required in accordance with CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

4. Corrective Action

a. Corrective action can be taken as a result of issues found through routine monitoring and subsequent PQI investigations in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review process, or as a result of issues found during formal investigations.

b. The corrective action may be for a non-medical/administrative reason or a medical, disciplinary cause or reason, and if, for a medical disciplinary cause or reason may result in a reportable action.

c. At the conclusion of the investigation, the CPRC shall determine whether to recommend any corrective action, and if so, whether the corrective action recommended is for a non-medical or medical disciplinary cause or reason, and will determine if action is reportable pursuant to CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

d. Corrective action for a Non-Medical Disciplinary Cause or Reason

i. If a corrective action is recommended for a "non-medical disciplinary cause or reason" such as customer service-related issues or delays in responding to medical records requests, which the CPRC may take, shall include, without limitation, the following:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant;

b) Sending the Practitioner a community best practice letter;

c) Recommending Practitioner education;

d) Recommending office staff training;

e) Requesting a written Corrective Action Plan (CAP), with appropriate time frames for correction, from the Practitioner demonstrating how the issue will be prevented in the future;

f) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action; or

g) Taking other actions deemed appropriate under the circumstances, including, but not limited to, closing physician panels or freezing specialist referrals.

ii. A corrective action for a "non-medical disciplinary cause or reason" shall not constitute a restriction of practice prerogatives, shall not be considered to be a reportable

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corrective action for a "medical disciplinary cause or reason" as that term is used in Section III.C.4.e. of this Policy, and shall not give rise to hearing rights as outlined in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

iii. If no improvement is found after the "non-medical disciplinary" corrective action is taken within the specified time frame, and the issue addressed in the action is a contractual requirement, the CPRC may escalate the case to CalOptima's Office of Compliance for further action.

e. Corrective action for a "Medical Disciplinary Cause or Reason"

i. If a corrective action is recommended for a "medical disciplinary cause or reason," CPRC may recommend one or more of the following actions:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

b) Sending the Practitioner a community best practice letter.

c) Recommending Practitioner education.

d) Recommending a written Corrective Action Plan from the Practitioner clearly demonstrating how the issue will be prevented in the future.

e) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action.

f) Recommending mandatory participation in: UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP).

g) Imposing, or the Practitioner's voluntarily acceptance of, a suspension of or restrictions on a Practitioner's provision of services to CalOptima Members.

h) Terminating the practitioner's participation in CalOptima's network.

ii. Actions taken for a "Medical Disciplinary Cause or Reason" may require reporting to the California Medical Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting. Reporting under that policy may also be required upon resignation or a leave of absence by a Practitioner from participation in CalOptima programs after notice of an investigation initiated for a "Medical or Disciplinary Cause or Reason."

iii. For an action that must be reportable under Section 805/809.1 hearing eligible, as described in CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network, include medical disciplinary cause or reasons such as:

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a) Incompetence;

b) Gross deviation from the standard of care;

c) Self-prescribing or self-administering controlled substances;

d) Abusing drugs or alcohol;

e) Repeated acts of excessive prescribing or providing controlled substances, and

f) Sexual misconduct with a patient.

iv. If the investigation concludes there is nothing of merit, no corrective action will be taken.

C. Subsequent Actions

1. If the CPRC recommends any reportable corrective action which would entitle a Practitioner to request a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, the CPRC shall give the Practitioner written notice of its recommendation, as provided in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners prior to imposing such action. A copy of that notice shall be sent to the QIC for informational purposes only. The CPRC shall also provide notice to CalOptima's Office of Compliance and to Legal Affairs. The written notice shall include:

a. The reasons for the action;

b. The standards and profiling data used to evaluate the Practitioner; and

c. Information regarding the Practitioner's appeal rights.

D. CPRC

1. Any CPRC action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIC.

2. If the CPRC does not recommend any corrective action which would entitle the CalOptima Practitioner to a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing for Practitioners, the CPRC shall either file its report with a recommendation of no further action or take the action that is not reportable.

3. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These medical disciplinary causes or reasons covered by Section 805.01 are:

a. Incompetence;

b. Gross deviation from the standard of care;

c. Self-prescribing or self-administering controlled substances;

d. Abusing drugs or alcohol;

e. Repeated acts of excessive prescribing or providing of controlled substances; and
f. Sexual misconduct with a patient.

E. Action Initiation by QIC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIC may direct the CPRC to initiate investigation or disciplinary action.

2. If the CPRC fails to take action in response to that direction from the QIC, the QIC may initiate corrective action.

F. Automatic Termination, Suspension or Limitation

1. A Practitioner shall inform the CMO promptly, and in writing, of any change in his or her compliance including, without limitation, professional license status, eligibility to participate in any federal health care program, including Medi-Cal or Medicare, compliance with CalOptima requirements for professional liability insurance, or conviction of a felony.

2. The Practitioner also must inform the CMO pursuant to this Section, if he/she is listed in the OIG List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) list, or the Medi-Cal Suspended and Ineligible Provider List).

3. In the following instances, the Practitioner's participation may be terminated, suspended, limited, restricted, or placed on probation as described, and such action shall be final, without any of the procedural rights described in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. Further, any other action required by CalOptima policies and contractual requirements with respect to the Practitioner's participation in (including through the Health Networks) shall be taken as applicable.

a. Licensure

i. Whenever a Practitioner's license or other legal credential authorizing practice in California is revoked, suspended, or lapses, the Practitioner's participation shall automatically be terminated as of the date such action becomes effective.

ii. Whenever a Practitioner's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, the Practitioner's participation with shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term, at least.

iii. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her participation status with CalOptima shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term, at least.

iv. Whenever a Practitioner's license or other legal credential is suspended, the Practitioner's participation shall be suspended, at least for the term of the suspension.

b. Controlled Substances

i. Whenever a Practitioner's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, or has expired, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.

ii. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term.

c. Medicare/Medi-Cal

i. If a Practitioner is suspended or excluded from participation or otherwise becomes ineligible to participate in Federal or State health care programs including, without limitation, the Medicare or Medi-Cal program, the Practitioner's participation shall automatically be terminated as of the effective date of the sanction.

d. Conviction of a Felony

i. A Practitioner who is convicted of any felony shall immediately and automatically be suspended. Such suspension is effective on conviction and does not await the conviction becoming final.

e. Professional Liability Insurance Eligibility

i. If, for any reason, a Practitioner fails to maintain professional liability insurance as required by CalOptima, the Practitioner's participation shall automatically be suspended until the Practitioner is covered by professional liability insurance acceptable to CalOptima.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, Section 805
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 Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Compliance Plan
G. CalOptima Quality Improvement Program
H. CalOptima Policy GG.1611: Potential Quality Issue Review Process

I. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
K. CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting
L. CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615Δ	CalOptima Direct Corrective Action Plan for Practitioners	
Revised	03/01/2013	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	TBD	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
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.
Credentialing and Peer Review Committee	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.
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.
Grievance	Any Complaint or dispute, other than an organization or coverage determination or late enrollment penalty determination, expressing dissatisfaction with the manner in which CalOptima, its providers or delegated entities provides health care services, or the operations, activities, or behavior, regardless of whether any remedial action can be taken.
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.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	A beneficiary enrolled in a CalOptima program.
Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing decision
Potential Quality Issue(s)	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.
Practitioner	A licensed independent 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), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

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Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

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Policy:	GG.1658Δ
Title:	**Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network**
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 defines the process that CalOptima shall use to impose a summary suspension or restriction on a Practitioner for a Medical Disciplinary Cause or Reason.

II. POLICY

A. Actions to suspend or restrict a Practitioner for a Medical Disciplinary Cause or Reason shall be conducted in accordance with the terms and conditions of this Policy.

B. Actions taken on the basis of Medical Disciplinary Cause or Reason shall be reportable under Section 805 of the California Business and Professions Code and to the National Practitioner Data Bank (NPDB) in accordance with CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

C. CalOptima shall notify a Practitioner in writing of a decision, which shall include reasons, standards, and data used to make such decisions to suspend, restrict, or terminate the Practitioner in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, within fifteen (15) days of final decision or recommendation by CPRC.

D. Health Networks shall have policies and procedures consistent with this policy that provide Practitioners with a pre-defined process when the Health Network takes or proposes action including summary suspension, automatic suspension, or limitation or termination related to a Practitioner's clinical practice.

III. PROCEDURE

A. Summary Suspension or Restriction

1. Whenever the failure to immediately suspend or restrict a Practitioner's practice in CalOptima may result in imminent danger to the health of any individual, the Credentialing and Peer Review Committee (CPRC), CalOptima Chief Medical Officer (CMO) or his or her physician Designee, shall have the authority to summarily suspend or restrict a contracted Practitioner's practice prerogatives.

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2. Any suspension or restriction imposed on a Practitioner for a Medical Disciplinary Cause or Reason shall include any notices or reporting required by CalOptima Policies GG.1616Δ: Fair Hearing Plan for Practitioners and GG.1657Δ: Medical Board and NPDB Reporting.

3. If the CPRC does not ratify such a summary suspension within two (2) CalOptima business days, the summary restriction or suspension shall terminate automatically.

4. Any restriction or suspension is subject to ratification by the CPRC. When such ratification is required, the Members shall be notified of the summary suspension immediately, both orally and in writing.

5. The CMO or designee shall file a report with the relevant agency within fifteen (15) days after the CPRC makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805 of the California Business and Profession Code, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs a. to d.. inclusive, may have occurred, regardless of whether a hearing is held pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. This report is in addition to any report that may be required under Section III.A.5.b. A Practitioner subject to reporting under this Section shall receive a notice of the proposed action as set forth in California Business and Profession Code Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to this Policy.

   b. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or to the public, or the extent that such use impairs the ability of the licentiate to practice safely.

   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be make in any complaint that may implicate these provisions.

   d. Sexual misconduct with one or more patients during a course of treatment or an examination.

B. Initiation of Summary Action

1. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall immediately give oral and written notice, via certified mail, to the Practitioner and also shall notify, in writing, the

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CMO, Chief Executive Officer (CEO), CPRC, and Quality Improvement Committee (QIC) within five (5) calendar days after such imposition of such suspension. The notice shall include the following:

a. Proposed action against Practitioner by the peer review body, which if adopted, shall be taken and reported pursuant to Section 805;

b. The final proposed action;

c. The Practitioner's right to request a hearing on the final proposed action pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; and

d. The time limit to request such a hearing.

2. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These medical disciplinary causes or reasons covered by Section 805.01 are:

a. Incompetence;

b. Gross deviation from the standard of care;

c. Self-prescribing or self-administering controlled substances;

d. Abusing drugs or alcohol;

e. Repeated acts of excessive prescribing or providing of controlled substances; and

f. Sexual misconduct with a patient.

3. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth in the notice.

4. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's Members shall be promptly assigned to another Practitioner considering, where feasible, the wishes of a Member in the choice of a substitute Practitioner.

C. CalOptima CPRC Action

1. Within two (2) CalOptima business days, after such summary restriction or suspension has been imposed, a meeting of the CPRC shall be convened to review and consider the action.

2. Notice provided to the CPRC of the summary action shall serve as a request for an investigation carried out pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

3. The CalOptima CPRC shall provide notice to the Practitioner that he or she may participate in the CPRC review and make a statement concerning the issues under investigation, on such terms and conditions as the CPRC may impose. In no event shall any such meeting of the

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CPRC, with or without the Practitioner, constitute a "hearing" nor shall any of the procedural rules for hearings apply, nor shall either party be represented by counsel.

4. The CPRC may modify, continue, or terminate the summary restriction or suspension.

5. The CPRC shall provide the Practitioner with notice of its decision.

6. The corrective action investigation shall be completed promptly to ensure any hearing on the summary suspension or restriction and corrective action can be commenced within the sixty (60) calendar day limit after a hearing on a summary suspension is requested. However, because of the summary nature of the action, reasonable efforts should be made to complete the investigation and to schedule the hearing as promptly as is feasible under the circumstances and as permitted by relevant law.

D. Procedural Rights

1. The Practitioner shall be entitled to hearings and appeals procedures pursuant to the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if the summary restriction or suspension is not promptly terminated by CPRC.

2. Any suspension that exceeds fourteen (14) calendar days shall be reported to the Medical Board of California in accordance with CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Business and Professional Code Section 809.1
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 Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Compliance Plan
G. CalOptima Quality Improvement Program
B. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
C. CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting
D. Business and Professions Code §§ 805.01 and 809.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	TBD	GG.1658Δ	Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) 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.
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.
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.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	A beneficiary enrolled in a CalOptima program.
Practitioner	A licensed independent 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), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16 Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

1. Ratify and authorize the unbudgeted expenditures in an amount up to $262,500 from existing reserves for mailing member education materials related to the Coronavirus (COVID-19) vaccination;
2. Authorize unbudgeted expenditures in an amount up to $695,974 from existing reserves for the COVID-19 Member Vaccination Incentive Program (VIP) to include the OneCare and OneCare Connect populations, subject to regulator(s) approval, as necessary;
3. Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $221,145 for staffing resources for the COVID-19 Member VIP; and
4. Authorize funding for staffing resources for the COVID-19 Member VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.

Background

On January 7, 2021, the CalOptima Board of Directors (Board) approved a COVID-19 Member VIP for calendar year 2021 (see Attachment 1). The goal of this program is to motivate members to get the required doses of COVID-19 vaccination by providing nonmonetary gift cards.

In addition to offering nonmonetary incentives, another essential strategy to promote vaccination is tailoring member education on the importance of vaccination and correcting misconceptions. As discussed at the Board's January 7, 2021 meeting, one element of the member communication plan is to mail information about the vaccine to all members. To provide this information in a timely manner, in February 2021, CalOptima has mailed member educational pieces (e.g., a cover letter addressing the importance of receiving vaccines, information on incentive administration, frequently asked questions, etc.) to all members. In addition, the texting campaign, which is another element of the strategy for member outreach, is currently pending approval by the Department of Health Care Services (DHCS), and staff will seek any additional required approvals as appropriate.

Staff also note that the OneCare (OC) and OneCare Connect (OCC) populations, among CalOptima's most vulnerable populations, were initially excluded from the COVID-19 Member VIP as this initiative is funded by IGT 10 dollars. In order to ensure the safety of these vulnerable populations and promote vaccination, staff recommend that the Board allocate additional funding for outreach and education of the OC and OCC members to align CalOptima's efforts with the County of Orange's COVID-19 Vaccine Equity Pilot Program (VEPP) deployment.

Back to Agenda

Discussion

Member Education Mailing

Staff have been working with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The program includes a mailing to all members with information about the vaccine. Mailing outreach allows members who do not have a mobile phone or access to internet services to receive CalOptima's COVID-19 Member VIP information and other important vaccine-related information.

Staff estimates that the total cost for mailing educational materials, including postage, envelop, and printing and fulfillment, is $250,000. In addition, staff estimates mailing approximately 5,000 to 5,500 gift cards each month from March through June 2021. The total estimated cost for gift card mailing is $12,500.

Expanding the COVID-19 Member VIP to OC and OCC

OC and OCC members are among the highest risk populations that CalOptima serves due to their age and underlying chronic conditions. The OC/OCC populations are not eligible for IGT dollars as Medicare is their primary health insurance coverage; therefore, they were excluded from the COVID-19 Member VIP request that was approved at the Board's January 7, 2021 meeting. In order to promote vaccination among these populations, staff recommends that the Board authorize unbudgeted expenditures to expand the COVID-19 Member VIP to include OC and OCC members, subject to regulator(s) approvals as necessary.

Staff estimates a 70% vaccine take-up rate by OC and OCC members. The total estimated cost for Medicare member incentive gift cards and related gift card activation fees is $64,000 for OC and $631,974 for OCC. Staff note that OC and OCC members residing in long-term care settings and PACE members are excluded from this COVID-19 Member VIP.

Staffing Resources for COVID-19 Member VIP

In order to deploy the COVID-19 Member VIP in a timely and effective manner, staff recommends hiring a dedicated Program Specialist, Int. and two temporary staff under the Population Health Management department. The Program Specialist, Int. will work with various internal and external stakeholders to execute the planned activities, track vaccination status and member incentive distribution status. Staff proposes making this position permanent beyond the pandemic as member incentive programs continue to grow, and permanent staff resources would be beneficial to support coordination and tracking of various member incentives. Temporary staff will support any administrative and data entry related responsibilities.

The estimated salary and benefit expenses for the Program Specialist, Int. is $147,225 for an 18 month period. The estimated cost for 2 temporary staff for a 9 month period or approximately 1,000 work hours is $73,920.

CalOptima staff proposes staffing resources for COVID-19 Member VIP for up to $221,145 through allocation of IGT 10 funds. It is anticipated that CalOptima's share of IGT 10 funds will be

approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021). Due to timing issues, staff requests the Board to authorize the CEO to approve this staff resources request prior to CalOptima's receipt of the IGT 10 funds from DHCS. As of February 1, 2021, the CalOptima Board of Directors has allocated $36.2 million of the anticipated IGT 10 funds, leaving $29.8 million unallocated. IGT 10 funds allocation recommendation requests totaling $221,145, including this one, are being made today. More information on IGT 10 is attached.

Fiscal Impact

The recommended actions to ratify and authorize mailing member education materials related to the COVID-19 vaccination and to include the OC and OCC populations in the COVID-19 Member VIP are unbudgeted items. An allocation of up to $958,474 from existing reserves will fund these actions.

The recommended action to allocate up to $221,145 for staffing resources for the COVID-19 Member VIP has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended for this purpose will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to promote vaccination for all members regardless of their eligibility program. The recommended actions will support CalOptima's efforts to help the community reach herd immunity and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated January 7, 2021, Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. Intergovernmental Transfers (IGT) 10 Summary

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, 714-246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

1. Authorize the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation;
2. Approve the recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed $20 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members age 14 and older for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); and
3. Authorize implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP.

Background

In late December 2020, the first doses of the COVID-19 vaccines arrived in Orange County. Vaccines will be distributed according to a phased approach, with high-priority groups vaccinated first and eventually the general public as determined by the California Department of Public Health and local health department. The U.S. Food and Drug Administration issued an emergency use authorization (EUA) for the Pfizer-BioNTech and Moderna vaccines, both of which offer more than 94% protection against COVID-19 when two doses are taken. Public health experts recommend that at least 70% of the population needs to get vaccinated to develop herd community, which can bring an end to the pandemic.

As the only Medi-Cal plan serving Orange County's most vulnerable residents, CalOptima is responding in collaboration with the Orange County Health Care Agency (OCHCA) to support the community in achieving herd immunity. The first step is a strategy that promotes COVID-19 vaccination, including tailoring member education on the importance of vaccination, dispelling misconceptions, and providing nonmonetary member incentives to ensure health equity across race, ethnicity and socioeconomic status. To support this effort, CalOptima staff is seeking an allocation of IGT 10 funds.

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 ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been

received, and IGT 10 funds will be distributed in two separate installments, which are expected from the state in 2021.

Discussion

Subject to state approval, staff will work with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The proposed program includes:

1. A mailing to all members with information about the vaccine.
2. A targeted text messaging campaign. When different priority groups are permitted to be vaccinated, CalOptima will send out targeted text messages to these members letting them know the following:
    a. They are now eligible to be vaccinated.
    b. Where they need to go to be vaccinated. (This information is not yet available, but staff continue to work with OCHCA to establish vaccine events in targeted geographic locations within the county. The vaccine events are likely to begin in Spring 2021, but may extend into the fall, depending on the vaccine distribution timeline as established by OCHCA.)
3. A targeted phone call campaign to population segments who are at high risk for not getting vaccinated. This will begin once the vaccine is widely available to at least essential workers, according to the phased approach.

Staff projects that as many as 400,000 members will participate in this program. To encourage members to participate in vaccination, staff proposes to provide two $25 nonmonetary gift cards for Medi-Cal members age 14 and older for receiving each of two doses of the COVID-19 vaccine, for a total of $50. Members will be encouraged to sign up with the OCHCA's app, Othena, at no cost, to receive the gift card incentives, one gift card for each shot received. The app is being developed to help healthcare providers track vaccine recipients to ensure they get a booster shot and to monitor for side effects. Staff is also seeking authority to enter into a Memorandum of Understanding (MOU) and/or contract or contract amendment with the County as necessary to implement the program. If it is subsequently determined that agreements with other entities, organizations or vendors are necessary, staff will return to the Board with further recommendations for consideration at a later date.

The targeted timeframe for the COVID-19 nonmonetary incentive is CY 2021. IGT 10 funds have not yet been received. 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 member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021).

Due to timing issues, staff requests that the Board authorize the CEO to implement the COVID-19 Vaccination Incentive Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from DHCS. Providing the nonmonetary incentive to coincide with the availability of the COVID-19 vaccination to members will support CalOptima's health promotion efforts in our community.

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, 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), rather than the medical loss ratio (MLR).

Fiscal Impact

The recommended action to allocate up to $20 million in IGT 10 funds to support the COVID-19 Vaccination Member Incentive Program has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended to implement the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends adding a COVID-19 vaccination member incentive component to CalOptima's preventive initiatives to educate and encourage member participation. The recommended actions will support CalOptima's efforts to help the community reach herd immunity, address health disparities, and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated February 6, 2020, Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

/s/ Richard Sanchez — *12/31/2020*
Authorized Signature — **Date**

ENTITITES COVERED BY THIS RECOMMENDED ACTION

Legal Name	Address	City	State	Zip code
County of Orange	405 W. 5th Street, Suite 756	Santa Ana	CA	92701

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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

15. Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

Contact

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

Recommended Actions

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 IGT Program for Rating Period 2019-20 (IGT 10);
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 IGT Program for Rating Period 2019-20 (IGT 10); and,
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 10 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 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 2010-11 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. 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.

The IGT funds received under IGTs 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.

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), beginning with IGT 8 funds must be used in the current rate year for CalOptima covered Medi-Cal services per DHCS direction. IGT 8 funds have been allocated to the Homeless Health Initiative. IGT 9 funds have not yet been received, nor allocated; CalOptima staff anticipates returning with recommendations on an allocation plan in a separate Board action; however, as indicated,

per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

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 Member's unmet healthcare needs.

Discussion

On December 20, 2019, CalOptima received notification from DHCS regarding the Rating Period 2019 - 20 Voluntary Rate Range IGT Program (IGT 10). Unlike the prior IGTs, which covered the applicable twelve-month state fiscal year, IGT 10 covers eighteen months including the periods of July 1, 2019 through June 30, 2020 and July 1, 2020. through December 31, 2020. CalOptima's proposal, along with the funding entities' supporting documents are due to DHCS no later than February 19, 2020.

The five eligible funding entities from the previous IGT transactions have been contacted regarding their interest in participation in IGT 10. All five funding entities have informally indicated that they are interested in participation in the IGT program this year. The formal DHCS required Letter of Interest is due to CalOptima by February 14, 2020 for delivery to DHCS by February 19, 2020. 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 authorize staff to submit the proposal letter to DHCS for participation in the 2019-20 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with each of the five proposed funding entities submitting a letter of interest (or their designated providers) for the purpose of securing available IGT funds. Consistent with the nine 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 the Board with additional information regarding the IGT 10 transaction and a proposed expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended actions to submit a proposal to DHCS and pursue IGT funding partnerships with five governmental funding entities for IGT 10 is expected to generate one-time IGT revenue that will be invested in covered Medi-Cal services for CalOptima members. As such, there is no net fiscal impact on CalOptima's current and future operating budgets.

Rationale for Recommendation

Consistent with the previous nine IGT transactions, submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2019-20 (IGT 10). Also, consistent with the 2020-22 Strategic Plan, it would increase funding to support delivery of covered Medi-Cal services for CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 15

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Children and Families Commission of Orange County	1505 E. 17th Street, 230	Santa Ana	CA	92705
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOME
GOVERNOR

DEC 2 0 2019

Nancy Huang
Interim Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Rating Period 2019–20 (July 1, 2019 through December 31, 2020) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Nancy Huang:

The Rating Period 2019-20 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 periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020.

DHCS shall not direct the MCP's expenditure of payments received under the Rating Period 2019-20 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 Rating Period 2019-20 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR RATING PERIOD 2019-20:

MCPs should refer to the estimated Rating Period 2019-20 (service periods July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020) 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 Rating Period 2019-20 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that for service periods July 1, 2019 through June 30, 2020 and July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Estimated Member Months, and the actual amounts may change based on actual enrollment. Note that for service period July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Projected Contribution PMPMs, and the actual amounts may change based on the risk adjustment process that DHCS uses as part of its rate development methodology.

If an MCP elect to participate in the Rating Period 2019-20 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 Rating Period 2019-20 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.
    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 Rating Period 2019-20. 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 Rating Period 2019-20 Voluntary Rate Range Program 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** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Wednesday, February 19, 2020.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Wednesday, February 19, 2020**. 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 Rating Period 2019-20 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 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 Rating Period 2019-20 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
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

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 service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020. 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 approximately $_____ for the Rating Period 2019-20 (July 1, 2019 through December 31, 2020) 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

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Rating Period 2019-20 (July 1, 2019 through December 31, 2020)

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 no later than February 19, 2020.**

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, 2018 - June 30, 2019.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2018 through June 30, 2019.

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. Please provide the following information:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(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. 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

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2019 - June 2020)

	Total	50% FFP (Non-MCHIP,SPD and LTC)	88% FFP (MCHIP - 7/2019 to 9/2019)	76.5% FFP (MCHIP - 10/2019 to 6/2020)	BCCTP[3]	WCM[4]	93% FFP Optional Expansion (7/2019 - 12/2019)	90% FFP Optional Expansion (1/2020 - 6/2020)
Total Funds Available	$ 143,831,947	$ 60,609,553	$ 2,248,273	$ 6,744,806	$ 567,560	$ 20,884,320	$ 26,388,727	$ 26,388,708
Federal Match	$ 98,389,329	$ 30,304,777	$ 1,978,480	$ 5,159,777	$ 189,344	$ 12,465,598	$ 24,541,516	$ 23,749,837
Governmental Funding Entity's Portion	$ 45,442,618	$ 30,304,776	$ 269,793	$ 1,585,029	$ 378,216	$ 8,418,722	$ 1,847,211	$ 2,638,871
	31.6%	50.0%	12.0%	23.5%	66.6%	40.3%	7.0%	10.0%

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 Departmental Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,271,664	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 15,356,449
Child - MCHIP 7/2019 - 9/2019	303,510	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,051,728
Child - MCHIP 10/2019 - 6/2020	910,531	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 6,155,190
Adult - non MCHIP	1,007,518	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 19,948,856
Adult - MCHIP 7/2019 - 9/2019	9,788	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 193,802
Adult - MCHIP 10/2019 - 6/2020	29,363	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 581,387
SPD	448,861	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 20,346,869
SPD/Full-Dual	24,336	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 235,572
BCCTP	7,026	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 567,560
LTC	15,492	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 4,721,807
LTC - MCHIP 7/2019 - 9/2019	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2019 - 6/2020	27	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 8,229
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	146,382	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 20,884,320
Optional Expansion 7/2019 - 12/2019	1,394,753	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,727
Optional Expansion 1/2020 - 6/2020	1,394,752	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,708
	7,964,012	$ 333.59	$ 353.87	$ 20.27	$ 2.21	$ 18.06	$ 143,831,947

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2020 - December 2020)

	Total	50% FFP (Non-MCHIP and SPD)	76.5% FFP (MCHIP - 7/2020 to 9/2020)	65% FFP (MCHIP - 10/2020 to 12/2020)	BCCTP [3]	WCM [4]	90% FFP Optional Expansion
Total Funds Available	$ 71,458,138	$ 30,053,529	$ 2,227,321	$ 2,227,321	$ 282,165	$ 10,402,926	$ 26,264,876
Federal Match	$ 47,878,762	$ 15,026,765	$ 1,703,901	$ 1,447,759	$ 94,133	$ 5,967,816	$ 23,638,388
Governmental Funding Entity's Portion	$ 23,579,376	$ 15,026,764	$ 523,420	$ 779,562	$ 188,032	$ 4,435,110	$ 2,626,488
	33.0%	50.0%	23.5%	35.0%	66.6%	42.6%	10.0%

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 Departmental Usage [2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	1,126,338	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 7,614,045
Child - MCHIP 7/2020 - 9/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Child - MCHIP 10/2020 - 12/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Adult - non MCHIP	493,892	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 9,779,062
Adult - MCHIP 7/2020 - 9/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
Adult - MCHIP 10/2020 - 12/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
SPD	224,524	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 10,177,673
SPD/Full-Dual	12,241	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 118,493
BCCTP	3,493	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 282,165
LTC	7,757	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,364,256
LTC - MCHIP 7/2020 - 9/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2020 - 12/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	72,916	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 10,402,926
Optional Expansion	1,388,207	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,264,876
	3,950,524	$ 334.30	$ 354.61	$ 20.31	$ 2.22	$ 18.09	$ 71,458,138

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

Intergovernmental Transfers (IGT) 10 Summary

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 ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received. IGT 10 funds are expected to be received from DHCS in two installments in 2021.

For the DHCS 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 member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021). As of February 1, 2021, the CalOptima Board of Directors has allocated $36.2 million of IGT 10 funds, leaving $29.8 unallocated as follows:

Date	Initiative	Amount
	Total Anticipated	**$66.0 million**
1/7/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion	$1.2 million
1/7/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021	$35.0 million
	Total Allocated	**$36.2 million**
	Unallocated	**$29.8 million**
	Total Allocation Recommendation Requested at the February 2021 Finance and Audit Committee Meeting	**$221,145**

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, 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), rather than the medical loss ratio (MLR).

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
17. Consider Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions
Recommend ratification and authorization of unbudgeted expenditures related to the coronavirus pandemic from existing reserves for emergency purchases in an amount not to exceed $17,925 through June 30, 2021.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers, partners, and the members we serve.

Discussion
To protect employees during the pandemic, CalOptima has implemented various infection control measures consistent with the guidelines provided by the Centers for Disease Control and Prevention (CDC) and other regulatory agencies. Additional expenditures are necessary as part of CalOptima's continued efforts to provide health and safety measures to protect employees who are working in CalOptima facilities.

The Occupational Safety and Health Administration (OSHA) has moved toward more aggressive and robust criteria to ensure workplace safety. Both the CDC and OSHA are focused on issuing recommendations that are expected to lead to significant changes to standards addressing safety in the office workplace environment.

In an effort to fully meet these requirements, staff is taking proactive steps to ensure that CalOptima worksites are safe and recommends the Board ratify and authorize unbudgeted expenditures related to the coronavirus pandemic for emergency purchases.

CalOptima contracted with existing vendors to ensure timely and efficient service and delivery of the required equipment and products for the protection and security of CalOptima's employees and members. Staff utilized the emergency bidding exception to perform an informal Request for Proposal (RFP) for the building path of travel signage, which was a new requirement by the CDC and OSHA. The RFP was released in September 2020, and CalOptima received two responses. The contract was awarded in October 2020 to Signarama.

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CalOptima contracted with our existing moving vendor in December 2020. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Department	Description	Amount
Facilities	505 Building Path of Travel signage (one-time expense)	$16,525
	505 Building: Temporary telework moving expenses: Estimate from December 2020 through June 2021	$1,400
	Total	**$17,925**

Fiscal Impact

The recommended action to ratify and authorize unbudgeted expenditures related to the coronavirus pandemic for emergency purchases is an unbudgeted item. An allocation of up to $17,925 from existing reserves will fund this action through June 30, 2021.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic
3. Board Action dated April 16, 2020, Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic
4. Board Action dated October 1, 2020, Consider Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Corovan	1000 East Valencia Drive	Fullerton	CA	92831
Signarama	1022 North Tustin Avenue	Anaheim	CA	92807

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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

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

Contact

Candice Gomez, Executive Director Program Implementation, (714) 246-8400
Brigette Gibb, Executive Director Human Resources, (714) 246-8400

Recommended Actions

1. Ratify the implementation of mitigation strategies to slow the transmission of COVID-19 through temporary telework for CalOptima employees; and
2. Ratify 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

Background

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."

Discussion

Along with federal, state, and local agencies, CalOptima management has been actively engaged in efforts to evaluate business needs and protect the health and safety of CalOptima employees, members, providers, and our community, and mitigate the spread and limit exposure to the disease. CalOptima management has been closely monitoring this public health emergency and taking preventive actions based on information and guidelines provided by federal, state, and local agencies including, but not limited to, the Centers for Disease Control and Prevention (CDC), the California Department of Public Health, and the Orange County Health Care Agency.
The health and safety of CalOptima employees is critical to ensuring business continuity and access to health care services for CalOptima members. CalOptima has considered the following objectives in evaluating the organization's response to the pandemic as the current situation constantly evolves:

- Maintaining continuity of essential services and business functions while maintaining a safe work environment for CalOptima employees;

- Maximizing social distancing and limiting group meetings and interactions that might spread COVID-19;
- Developing flexible work arrangements for employees as appropriate;
- Maintaining a unified response consistent with actions taken by state and local government; and
- Ensuring that CalOptima is transparent in its processes and communications to its employees, providers and members.

CalOptima's operations are considered part of the critical infrastructure in both the healthcare/public health sector as well as the government sector. As an essential business, CalOptima's operations must continue to be fully functioning and effective. As part of business continuity and emergency planning, CalOptima management has evaluated job functions, and categorized CalOptima staff according to the following five categories:

1. Job duties cannot be performed remotely;
2. Job duties can be performed remotely;
3. Job duties support essential functions in the 505 City Parkway West building:
    - Facility support
    - Building security
    - Building management
    - Information Services 3rd Shift
    - Information Services Help Desk
    - Mail room
    - Member enrollment and reconciliation
    - Finance accounts payable;
4. Job duties support essential functions in the PACE Center, 13300 Garden Grove Blvd:
    - PACE clinic, transportation, and reception staff
    - PACE records management; and
5. Job duties can be performed remotely, but employee's home environment is not conducive to working remotely.

To protect employees during the pandemic, CalOptima management has been implementing infection control and social distancing measures as these are released by the CDC or other regulatory agencies. Based on the guidelines provided by regulatory agencies, on March 13, 2020, CalOptima management has moved forward with its business continuity and emergency plan, and initiated temporary telework for CalOptima staff whose job duties can be performed remotely. In order to institute an orderly process for temporary telework, CalOptima management implemented phases for deployment. This process was made voluntary to employees and only applied to those with job duties that meet the requirements for temporary telework.

> Phase 1: Employees identified in the high risk categories (as defined by CDC guidelines as of March 13, 2020), including those eligible for leave under the Family Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA), or those requiring a reasonable accommodation under the Americans with Disabilities Act (ADA).

Phase 2: Employees who had already been issued the necessary equipment to work remotely.

Phase 3: Employees who had not previously been issued the necessary equipment to work remotely have been and will continue to be deployed when fully equipped and according to job function with the following priority:

a. Employees with direct member interaction (e.g., talk to Members);
b. Employees whose job duties result in an organizational decisions or determinations (e.g., approval, denial, or appeal of medical service authorization requests);
c. All other staff as equipment needs are met.

The temporary telework process was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and the number of employees on temporary telework exceeds the Board-authorized number of teleworkers (1/3 of CalOptima staff). Currently, approximately 82% of CalOptima employees are working remotely, and management anticipates that this number may increase to as many as 85-90%. Management is seeking Board ratification of the actions taken to respond to the COVID-19 pandemic and implement mitigation strategies by placing employees on temporary telework, which:

(1) Reduces the number of employees present in the administration building and facilitates social distancing measures to mitigate the spread of COVID-19;
(2) Ensures business continuity while employees are working remotely;
(3) Protects the health and safety of CalOptima employees; and
(4) Ensures that CalOptima is continuing to carry out its essential operations by meeting the needs of members and being responsive to providers.

To support temporary telework, CalOptima staff also recommends ratification of unbudgeted expenditures in the amount of $915,000 for equipment and mobile ready software to allow CalOptima employees to work remotely. Expenditures also include replenishment of back-up laptop inventory plus additional laptops for urgent and unforeseeable needs due to COVID-19. The recommended amount of unbudgeted expenditures is based on estimated costs and approximately 10% contingency for unanticipated costs. Estimated itemized costs are as follows:

Item	**Amount**
RSA Tokens to allow connectivity outside of building	$43,911
VPN Licenses to allow connectivity to the CalOptima network	$76,600
IP Softphone Licenses to allow connectivity to the phone system	$259,893
Power Cords	$4,505
Headsets and Headset Adapters	$42,185
Surge Protectors	$10,532
Cables and Soundbars for Computer Monitors	$28,458

ACD License to support phone system	$38,510
Bluecoat Web Security Service (WSS)	$21,970
Computer Monitors	$184,145
Cat6 Patch Cables for Computer Parts	$759
Back-up Laptops	$121,879
Contingency	$81,653
Estimated Costs	$915,000

For employees remaining in the two CalOptima buildings, additional space planning efforts have been implemented to promote social distancing practices. Additional planning is also being evaluated should it be necessary through local, state, or federal action that employees remain locked-down at home and all essential work functions must be performed remotely. CalOptima staff will return to the CalOptima Board of Directors for consideration of future actions as appropriate.

Fiscal Impact

The recommended action to ratify unbudgeted expenditures for emergency purchases to support CalOptima's response to the public health emergency and implementation of temporary telework is unbudgeted. An allocation of up to $915,000 from existing reserves will fund this action.

Rationale for Recommendation

Implementing temporary telework ensures that CalOptima takes appropriate action to not only protect the health and safety of our employees and community during the COVID-19 pandemic, but also ensure that CalOptima members and providers are able to access covered, medically necessary health care services during this pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Temporary Telework Agreement
2. CalOptima Policy GG.8044 Telework Program

/s/ Michael Schrader — *03/26/2020*
Authorized Signature — **Date**

CalOptima Temporary Telework Agreement

Name:	
Title:	
Department:	
Supervisor/Manager:	
Reason for Request:	☐ **Health conditions resulting in a higher risk** ☐ **Direct exposure to individual with COVID-19** ☐ **Suspected exposure to individual with COVID-19** ☐ **Caring for family member with COVID-19** ☐ **Quarantine order by government entity** ☐ **Minor illness or influence/cold-like illness** ☐ **Childcare as a result of school closure** ☐**Specify school district:** _____ ☐**School closure dates:** _____ ☐ **Travel to/from particular locations with known outbreaks** ☐ **Other: Please specify** _____
Temporary Telework Start Date:	
Anticipated Return Date:	

CalOptima recognizes the unique circumstances surrounding the current COVID-19 pandemic and would like to support alternative work arrangements, where feasible, to help protect CalOptima employees and prevent the further spread of the virus. A voluntary temporary telework arrangement is being made available as an alternative method of meeting the work needs of the organization through a flexible work structure for positions where the essential functions of the job can be performed off-site. This temporary telework agreement will commence once approved by the Human Resources Department, and the termination date will be evaluated weekly based on the conditions and circumstances surrounding COVID-19. You may need to take PTO or unpaid leave if you cannot come to the Office, but are either not yet approved for temporary telework or do not yet have the necessary equipment to perform the essential functions of your job position. Please maintain regular contact with your management regarding your attendance, and HR regarding protected leave and/or reasonable accommodations.

I _____, ("Employee") and CalOptima, mutually agree that the
Print Name

Employee is eligible to work at a Remote Work Location, on a temporary basis, commencing on the date approved by HR below pursuant to this Temporary Telework.
Work Agreement (the "Agreement"). This is not considered or counted as a permanent telework position and will only be granted for the amount of time necessary. This privilege is voluntary, temporary and may be terminated at any time by CalOptima, the employee or manager.

Participation:

CalOptima plays a vital role in the community as a resource for care, information, and support. Our focus is to enable our employees to manage the community response and to serve the needs of CalOptima members, while also taking care of our own employees. Employee recognizes that the temporary telework option is voluntary and at the Employee's discretion. This work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Approval of the temporary telework arrangement will be made based on an evaluation of the appropriateness of your position to work from home, the resources available to enable you to work, business priorities, and staffing concerns. Business continuity for critical areas is our utmost priority to ensure CalOptima is providing excellent services to our members and responding in a timely manner to all inquiries and regulatory requirements.

Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA. 8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI-security of CalOptima assets, dependent care, etc.
b. Employee understands and agrees that the temporary telework arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site, with particular sensitivity to any protected health information in written or oral form. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for temporary telework as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

CalOptima may terminate this agreement at any time, with or without notice.

Employee:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

APPROVED BY HUMAN RESOURCES:

Print Name	Signature	Date

Policy #:	GA.8044
Title:	**Telework Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader MS

Effective Date:	03/01/12
Last Review Date:	02/01/18
Last Revised Date:	02/01/18

Board Approved Policy

I. PURPOSE

This policy describes guidelines for a work structure that: 1) permits an employee to perform their work from a Remote Work Location, unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

II. POLICY

A. Telework is a workplace arrangement in which an eligible employee works his or her entire work schedule away from the Central Worksite at a Remote Work Location, unless business needs require otherwise.

1. A partial teleworking arrangement is not allowed. A Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location.

B. Telework is not a universal employee benefit or entitlement, but rather, an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the telework program based on business needs.

C. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

D. The total number of employees in telework positions at any point in time may equal but not exceed the maximum number telework positions as directed by the CalOptima Board of Directors.

E. Telework positions may be identified as follows:

1. Human Resources (HR) may designate a position as a telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite.

F. Remote Work exception to the Telework policy: When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a Remote Work Location on an occasional basis.

1. Occasional is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position.

2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, establishing a Remote Work Location, security of CalOptima assets, inspection, etc.

3. Furthermore, for departments which permit employees to work from a Remote Work Location, to be eligible to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

G. Terms of Employment

1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.

2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.

3. Telework will be voluntary unless specifically stated as a condition of employment.

4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

H. Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

b. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) regulations.

c. The nature of the work and the employee's job responsibilities do not require daily face-to-face contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

d. The nature of the work is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

2. To be eligible for telework, the following considerations will be evaluated:

a. Employee must be in good standing, with no prior disciplinary action in the last year or on a Performance Improvement Plan, and may be scheduled for full-time or part-time and/or may be exempt or non-exempt (hourly).

b. Based on business considerations and management discretion, supervisors and managers may be approved for telework only if their entire team teleworks.

c. If supervisors and managers have staff that does not telework and/or are not eligible for telework, they must be present in the office to supervise their non-telework staff.

d. Telework is not available for senior manager level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Operating Officer.

3. To participate in the telework program, an employee must meet additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.

4. To be eligible to work from a Remote Work Location the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

I. Termination of Telework Arrangement

1. A Teleworker may elect at any time to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

    a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

J. Work Schedule and Accessibility

1. A Teleworker's schedule of work hours, including breaks, overtime, and deviations from regular work hours, should be approved by the Teleworker's manager.

    a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, or the progress of individual or team assignments.

    b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to: meetings, consultations, presentations and conferences.

    c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate manager supervision and communication.

2. The number of hours normally scheduled to work by an employee shall not change because of telework.

3. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

4. Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance.

5. An exempt Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.

6. Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

7. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

8. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers or members.

9. When visiting the Central Worksite, a Teleworker will notify their direct supervisor or alternate of their presence in office building, including their physical location and tentative length of stay.

10. A Teleworker will attend job-related meetings, training sessions, and conferences, as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

11. During telework hours, a Teleworker must be reachable via telephone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

12. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.

K. Dependent Care

1. A Teleworker will **not** act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make dependent care arrangements to permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

L. Deployment Preparation

1. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Understanding the policies and procedures of telework is an important determinant of success in the telework program. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

M. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

   a. A Teleworker must set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

   b. Preferably, this workspace will be a separate room that is designated as a home office.

   c. The home office location and specified workstation and internet access must be in compliance with the EH&S standards and the safety checklists.

d. The employee must sign and submit the CalOptima Teleworking Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold face-to-face business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

   a. CalOptima will provide advanced notice of any delivery.

   b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

   a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office Locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

   a. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils).

   b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker.

N. Teleworker Performance Management

1. The manager and Teleworker will develop and agree upon any relevant goals and performance guidelines, as well as the frequency of performance discussions.

2. The manager of the Teleworker shall:

   a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

   b. Provide timely and specific feedback to the Teleworker on a regular basis.

c. Plan for and use multiple channels to keep the Teleworker informed and up-to-date about departmental and CalOptima activities.

d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

O. Program Reporting and Evaluation

1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards and outcomes for the Teleworkers to HR upon request.

P. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.

5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.

a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

a. A Teleworker's property;

b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

Q. Compliance: Handling PHI from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location.

2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite through the use of:

a. Binders; or

b. Folders or other protective cover.

4. Upon their disposal, a Teleworker shall shred all PHI documents or files. A Teleworker shall transport PHI documents that are taken to the Remote Work Location and ready for destruction back to the Central Worksite for shredding.

5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

R. Use of Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

2. A Teleworker shall adhere to the following information security procedures:

a. Maintain the confidentiality of his or her user sign-on identification code and password;

b. Keep the PC or laptop secure at all times;

c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;

d. Ensure that passwords or operating instructions are not stored with the computer; and

e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:

a. Loss of a PC or laptop;

b. Software irregularities indicating possible virus infection; and

c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include disciplinary action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

S. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.

T. Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

U. Security of CalOptima Assets

1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must only be used by the Teleworker and may not be used by other guests or individuals for personal use.

3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

   a. Not returned at the conclusion of employment; or

   b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

V. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into **the Central Worksite** from a local Remote Worksite Location.

2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

W. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

X. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in: termination of the employee's telework arrangement and/or disciplinary action, up to and including termination of the employee. Certain violations of this Policy, other

applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima Telework Agreement
B. CalOptima Occasional Off-site Work Agreement

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.5004: Travel Policy
C. CalOptima Policy GA.8000: Glossary of Terms
D. CalOptima Policy GA.8020: 9/80 Work Schedule
E. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
D. 06/06/13: Regular Meeting of the CalOptima Board of Directors
E. 03/01/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	03/01/2012	GA.8044	Telework Program	Administrative
Revised	06/06/2013	GA.8044	Telework Program	Administrative
Revised	05/01/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A designated workspace within the Teleworker' residence.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Remote Work Location	The Employee's Home Office or designated pre-approved work location.
Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item
4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and

2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of $20,000 from the Professional Fees budget to fund these contracts.

Discussion
Emergency Purchases Related to Coronavirus Pandemic
Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$30,110
	Member personal protective equipment	$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	$30,000
Facilities	Staff personal protective equipment	$11,905
	Gloves, disinfectant products	$578

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Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 ($1,000/month)	$3,000
	Total	**$80,327**

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is $48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to $128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez — *04/10/2020*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

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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.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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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/

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

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
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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

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
Recommend ratification and authorization of unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $137,802.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the CalOptima Board of Directors ratified and authorized unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000.

At its April 16, 2020, meeting, the Board ratified and authorized additional unbudgeted expenditures for emergency purchases related to the coronavirus pandemic not to exceed $80,327.

Discussion
To protect employees during the pandemic, CalOptima has implemented various infection control measures consistent with the guidelines provided by the CDC and other regulatory agencies. Additional expenditures are necessary as part of CalOptima's continued efforts to provide health and safety measures to protect employees who are working in the CalOptima facilities. Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$21,300
Facilities	Staff personal protective equipment	$8,780
	Gloves, disinfectant products	$11,653
	Thermometers	$2,069
	Estimated expenses for disinfectant products ($1,000/month) and other COVID-related supplies from July 1, 2020, through December 31, 2020	$19,000

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Department	Description	Amount
Facilities and Payroll	2 temporary staff in Facilities to perform remote workplace evaluation. 1 temporary staff in Payroll to: • Improve timekeeping management process during Temporary Telework deployment; and • Assist with handling and processing of paperwork, and other support during the pandemic.	$75,000
	Total	**$137,802**

CalOptima contracted with the existing vendors to ensure timely and efficient service and delivery of the required equipment and products for the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Fiscal Impact

The recommended action to ratify and authorize unbudgeted expenditures for emergency purchases to support CalOptima's continued response to the public health emergency related to the coronavirus pandemic is unbudgeted. An allocation of up to $137,802 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachments

1. Board Action dated April 2, 2020, Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic
2. Board Action dated April 16, 2020, Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Candice Gomez, Executive Director Program Implementation, (714) 246-8400
Brigette Gibb, Executive Director Human Resources, (714) 246-8400

Recommended Actions

1. Ratify the implementation of mitigation strategies to slow the transmission of COVID-19 through temporary telework for CalOptima employees; and
2. Ratify 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

Background

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."

Discussion

Along with federal, state, and local agencies, CalOptima management has been actively engaged in efforts to evaluate business needs and protect the health and safety of CalOptima employees, members, providers, and our community, and mitigate the spread and limit exposure to the disease. CalOptima management has been closely monitoring this public health emergency and taking preventive actions based on information and guidelines provided by federal, state, and local agencies including, but not limited to, the Centers for Disease Control and Prevention (CDC), the California Department of Public Health, and the Orange County Health Care Agency.
The health and safety of CalOptima employees is critical to ensuring business continuity and access to health care services for CalOptima members. CalOptima has considered the following objectives in evaluating the organization's response to the pandemic as the current situation constantly evolves:

- Maintaining continuity of essential services and business functions while maintaining a safe work environment for CalOptima employees;

- Maximizing social distancing and limiting group meetings and interactions that might spread COVID-19;
- Developing flexible work arrangements for employees as appropriate;
- Maintaining a unified response consistent with actions taken by state and local government; and
- Ensuring that CalOptima is transparent in its processes and communications to its employees, providers and members.

CalOptima's operations are considered part of the critical infrastructure in both the healthcare/public health sector as well as the government sector. As an essential business, CalOptima's operations must continue to be fully functioning and effective. As part of business continuity and emergency planning, CalOptima management has evaluated job functions, and categorized CalOptima staff according to the following five categories:

1. Job duties cannot be performed remotely;
2. Job duties can be performed remotely;
3. Job duties support essential functions in the 505 City Parkway West building:
    - Facility support
    - Building security
    - Building management
    - Information Services 3rd Shift
    - Information Services Help Desk
    - Mail room
    - Member enrollment and reconciliation
    - Finance accounts payable;
4. Job duties support essential functions in the PACE Center, 13300 Garden Grove Blvd:
    - PACE clinic, transportation, and reception staff
    - PACE records management; and
5. Job duties can be performed remotely, but employee's home environment is not conducive to working remotely.

To protect employees during the pandemic, CalOptima management has been implementing infection control and social distancing measures as these are released by the CDC or other regulatory agencies. Based on the guidelines provided by regulatory agencies, on March 13, 2020, CalOptima management has moved forward with its business continuity and emergency plan, and initiated temporary telework for CalOptima staff whose job duties can be performed remotely. In order to institute an orderly process for temporary telework, CalOptima management implemented phases for deployment. This process was made voluntary to employees and only applied to those with job duties that meet the requirements for temporary telework.

> Phase 1: Employees identified in the high risk categories (as defined by CDC guidelines as of March 13, 2020), including those eligible for leave under the Family Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA), or those requiring a reasonable accommodation under the Americans with Disabilities Act (ADA).

Phase 2: Employees who had already been issued the necessary equipment to work remotely.

Phase 3: Employees who had not previously been issued the necessary equipment to work remotely have been and will continue to be deployed when fully equipped and according to job function with the following priority:

a. Employees with direct member interaction (e.g., talk to Members);
b. Employees whose job duties result in an organizational decisions or determinations (e.g., approval, denial, or appeal of medical service authorization requests);
c. All other staff as equipment needs are met.

The temporary telework process was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and the number of employees on temporary telework exceeds the Board-authorized number of teleworkers (1/3 of CalOptima staff). Currently, approximately 82% of CalOptima employees are working remotely, and management anticipates that this number may increase to as many as 85-90%. Management is seeking Board ratification of the actions taken to respond to the COVID-19 pandemic and implement mitigation strategies by placing employees on temporary telework, which:

(1) Reduces the number of employees present in the administration building and facilitates social distancing measures to mitigate the spread of COVID-19;
(2) Ensures business continuity while employees are working remotely;
(3) Protects the health and safety of CalOptima employees; and
(4) Ensures that CalOptima is continuing to carry out its essential operations by meeting the needs of members and being responsive to providers.

To support temporary telework, CalOptima staff also recommends ratification of unbudgeted expenditures in the amount of $915,000 for equipment and mobile ready software to allow CalOptima employees to work remotely. Expenditures also include replenishment of back-up laptop inventory plus additional laptops for urgent and unforeseeable needs due to COVID-19. The recommended amount of unbudgeted expenditures is based on estimated costs and approximately 10% contingency for unanticipated costs. Estimated itemized costs are as follows:

Item	**Amount**
RSA Tokens to allow connectivity outside of building	$43,911
VPN Licenses to allow connectivity to the CalOptima network	$76,600
IP Softphone Licenses to allow connectivity to the phone system	$259,893
Power Cords	$4,505
Headsets and Headset Adapters	$42,185
Surge Protectors	$10,532
Cables and Soundbars for Computer Monitors	$28,458

ACD License to support phone system	$38,510
Bluecoat Web Security Service (WSS)	$21,970
Computer Monitors	$184,145
Cat6 Patch Cables for Computer Parts	$759
Back-up Laptops	$121,879
Contingency	$81,653
Estimated Costs	$915,000

For employees remaining in the two CalOptima buildings, additional space planning efforts have been implemented to promote social distancing practices. Additional planning is also being evaluated should it be necessary through local, state, or federal action that employees remain locked-down at home and all essential work functions must be performed remotely. CalOptima staff will return to the CalOptima Board of Directors for consideration of future actions as appropriate.

Fiscal Impact

The recommended action to ratify unbudgeted expenditures for emergency purchases to support CalOptima's response to the public health emergency and implementation of temporary telework is unbudgeted. An allocation of up to $915,000 from existing reserves will fund this action.

Rationale for Recommendation

Implementing temporary telework ensures that CalOptima takes appropriate action to not only protect the health and safety of our employees and community during the COVID-19 pandemic, but also ensure that CalOptima members and providers are able to access covered, medically necessary health care services during this pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Temporary Telework Agreement
2. CalOptima Policy GG.8044 Telework Program

/s/ Michael Schrader — *03/26/2020*
Authorized Signature — **Date**

CalOptima Temporary Telework Agreement

Name:	
Title:	
Department:	
Supervisor/Manager:	
Reason for Request:	☐ **Health conditions resulting in a higher risk** ☐ **Direct exposure to individual with COVID-19** ☐ **Suspected exposure to individual with COVID-19** ☐ **Caring for family member with COVID-19** ☐ **Quarantine order by government entity** ☐ **Minor illness or influence/cold-like illness** ☐ **Childcare as a result of school closure** ☐**Specify school district:** _____ ☐**School closure dates:** _____ ☐ **Travel to/from particular locations with known outbreaks** ☐ **Other: Please specify** _____
Temporary Telework Start Date:	
Anticipated Return Date:	

CalOptima recognizes the unique circumstances surrounding the current COVID-19 pandemic and would like to support alternative work arrangements, where feasible, to help protect CalOptima employees and prevent the further spread of the virus. A voluntary temporary telework arrangement is being made available as an alternative method of meeting the work needs of the organization through a flexible work structure for positions where the essential functions of the job can be performed off-site. This temporary telework agreement will commence once approved by the Human Resources Department, and the termination date will be evaluated weekly based on the conditions and circumstances surrounding COVID-19. You may need to take PTO or unpaid leave if you cannot come to the Office, but are either not yet approved for temporary telework or do not yet have the necessary equipment to perform the essential functions of your job position. Please maintain regular contact with your management regarding your attendance, and HR regarding protected leave and/or reasonable accommodations.

I _____, ("Employee") and CalOptima, mutually agree that the
Print Name

Employee is eligible to work at a Remote Work Location, on a temporary basis, commencing on the date approved by HR below pursuant to this Temporary Telework.
Work Agreement (the "Agreement"). This is not considered or counted as a permanent telework position and will only be granted for the amount of time necessary. This privilege is voluntary, temporary and may be terminated at any time by CalOptima, the employee or manager.

Participation:

CalOptima plays a vital role in the community as a resource for care, information, and support. Our focus is to enable our employees to manage the community response and to serve the needs of CalOptima members, while also taking care of our own employees. Employee recognizes that the temporary telework option is voluntary and at the Employee's discretion. This work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Approval of the temporary telework arrangement will be made based on an evaluation of the appropriateness of your position to work from home, the resources available to enable you to work, business priorities, and staffing concerns. Business continuity for critical areas is our utmost priority to ensure CalOptima is providing excellent services to our members and responding in a timely manner to all inquiries and regulatory requirements.

Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA. 8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI-security of CalOptima assets, dependent care, etc.
b. Employee understands and agrees that the temporary telework arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site, with particular sensitivity to any protected health information in written or oral form. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for temporary telework as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

CalOptima may terminate this agreement at any time, with or without notice.

Employee:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

APPROVED BY HUMAN RESOURCES:

Print Name	Signature	Date

Policy #:	GA.8044
Title:	**Telework Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader MS

Effective Date:	03/01/12
Last Review Date:	02/01/18
Last Revised Date:	02/01/18

Board Approved Policy

I. PURPOSE

This policy describes guidelines for a work structure that: 1) permits an employee to perform their work from a Remote Work Location, unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

II. POLICY

A. Telework is a workplace arrangement in which an eligible employee works his or her entire work schedule away from the Central Worksite at a Remote Work Location, unless business needs require otherwise.

1. A partial teleworking arrangement is not allowed. A Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location.

B. Telework is not a universal employee benefit or entitlement, but rather, an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the telework program based on business needs.

C. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

D. The total number of employees in telework positions at any point in time may equal but not exceed the maximum number telework positions as directed by the CalOptima Board of Directors.

E. Telework positions may be identified as follows:

1. Human Resources (HR) may designate a position as a telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite.

F. Remote Work exception to the Telework policy: When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a Remote Work Location on an occasional basis.

1. Occasional is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position.

2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, establishing a Remote Work Location, security of CalOptima assets, inspection, etc.

3. Furthermore, for departments which permit employees to work from a Remote Work Location, to be eligible to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

G. Terms of Employment

1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.

2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.

3. Telework will be voluntary unless specifically stated as a condition of employment.

4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

H. Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

b. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) regulations.

c. The nature of the work and the employee's job responsibilities do not require daily face-to-face contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

d. The nature of the work is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

2. To be eligible for telework, the following considerations will be evaluated:

a. Employee must be in good standing, with no prior disciplinary action in the last year or on a Performance Improvement Plan, and may be scheduled for full-time or part-time and/or may be exempt or non-exempt (hourly).

b. Based on business considerations and management discretion, supervisors and managers may be approved for telework only if their entire team teleworks.

c. If supervisors and managers have staff that does not telework and/or are not eligible for telework, they must be present in the office to supervise their non-telework staff.

d. Telework is not available for senior manager level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Operating Officer.

3. To participate in the telework program, an employee must meet additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.

4. To be eligible to work from a Remote Work Location the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

I. Termination of Telework Arrangement

1. A Teleworker may elect at any time to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

    a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

J. Work Schedule and Accessibility

1. A Teleworker's schedule of work hours, including breaks, overtime, and deviations from regular work hours, should be approved by the Teleworker's manager.

    a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, or the progress of individual or team assignments.

    b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to: meetings, consultations, presentations and conferences.

    c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate manager supervision and communication.

2. The number of hours normally scheduled to work by an employee shall not change because of telework.

3. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

4. Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance.

5. An exempt Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.

6. Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

7. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

8. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers or members.

9. When visiting the Central Worksite, a Teleworker will notify their direct supervisor or alternate of their presence in office building, including their physical location and tentative length of stay.

10. A Teleworker will attend job-related meetings, training sessions, and conferences, as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

11. During telework hours, a Teleworker must be reachable via telephone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

12. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.

K. Dependent Care

1. A Teleworker will **not** act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make dependent care arrangements to permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

L. Deployment Preparation

1. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Understanding the policies and procedures of telework is an important determinant of success in the telework program. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

M. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

   a. A Teleworker must set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

   b. Preferably, this workspace will be a separate room that is designated as a home office.

   c. The home office location and specified workstation and internet access must be in compliance with the EH&S standards and the safety checklists.

d. The employee must sign and submit the CalOptima Teleworking Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold face-to-face business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

   a. CalOptima will provide advanced notice of any delivery.

   b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

   a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office Locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

   a. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils).

   b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker.

N. Teleworker Performance Management

1. The manager and Teleworker will develop and agree upon any relevant goals and performance guidelines, as well as the frequency of performance discussions.

2. The manager of the Teleworker shall:

   a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

   b. Provide timely and specific feedback to the Teleworker on a regular basis.

c. Plan for and use multiple channels to keep the Teleworker informed and up-to-date about departmental and CalOptima activities.

d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

O. Program Reporting and Evaluation

1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards and outcomes for the Teleworkers to HR upon request.

P. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.

5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.

a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

a. A Teleworker's property;

b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

Q. Compliance: Handling PHI from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location.

2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite through the use of:

a. Binders; or

b. Folders or other protective cover.

4. Upon their disposal, a Teleworker shall shred all PHI documents or files. A Teleworker shall transport PHI documents that are taken to the Remote Work Location and ready for destruction back to the Central Worksite for shredding.

5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

R. Use of Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

2. A Teleworker shall adhere to the following information security procedures:

a. Maintain the confidentiality of his or her user sign-on identification code and password;

b. Keep the PC or laptop secure at all times;

c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;

d. Ensure that passwords or operating instructions are not stored with the computer; and

e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:

a. Loss of a PC or laptop;

b. Software irregularities indicating possible virus infection; and

c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include disciplinary action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

S. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.

T. Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

U. Security of CalOptima Assets

1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must only be used by the Teleworker and may not be used by other guests or individuals for personal use.

3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

   a. Not returned at the conclusion of employment; or

   b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

V. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into **the Central Worksite** from a local Remote Worksite Location.

2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

W. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

X. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in: termination of the employee's telework arrangement and/or disciplinary action, up to and including termination of the employee. Certain violations of this Policy, other

applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima Telework Agreement
B. CalOptima Occasional Off-site Work Agreement

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.5004: Travel Policy
C. CalOptima Policy GA.8000: Glossary of Terms
D. CalOptima Policy GA.8020: 9/80 Work Schedule
E. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
D. 06/06/13: Regular Meeting of the CalOptima Board of Directors
E. 03/01/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	03/01/2012	GA.8044	Telework Program	Administrative
Revised	06/06/2013	GA.8044	Telework Program	Administrative
Revised	05/01/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A designated workspace within the Teleworker' residence.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Remote Work Location	The Employee's Home Office or designated pre-approved work location.
Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item
4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and

2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of $20,000 from the Professional Fees budget to fund these contracts.

Discussion
Emergency Purchases Related to Coronavirus Pandemic
Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$30,110
	Member personal protective equipment	$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	$30,000
Facilities	Staff personal protective equipment	$11,905
	Gloves, disinfectant products	$578

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Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 ($1,000/month)	$3,000
	Total	**$80,327**

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is $48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to $128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez — *04/10/2020*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

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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.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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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

I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

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EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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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

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Action

Recommend ratifying reapportionment of budgeted funds among capital expense categories for various Information Systems capital projects.

Background/Discussion

CalOptima Policy GA.5003: Budget and Operations Forecasting includes provisions that delegate authority to the Chief Executive Officer (CEO) to make budget allocation changes within certain parameters. Pursuant to this policy, budget allocations between different capital expense categories for the Board-approved capital project (e.g., hardware, software and professional fees related to implementation for Information Systems) require Board approval. Management is looking into the options for the Board to consider delegating authority to the CEO to make budget expense category changes within certain parameters for Board-approved capital projects as Staff may not always have sufficient information at the time of budgeting to accurately estimate actual costs by expense category within a particular project. Capital budget projects may carry over into subsequent years if they have been initiated or are in progress.

The CalOptima FY 2019-20 Capital Budget was approved by the CalOptima Board of Directors on June 6, 2019. Information Systems represent $9.6 million of the total Capital Budget and were budgeted by asset categories. Staff included the best available information at the time of budgeting. During the procurement process performed in accordance with CalOptima Policy GA.5022, the quoted pricing from vendors did not fall within the Board-approved expense categories. Management recommends ratification of the reapportionment of budgeted funds among capital expense categories for the Information System capital projects summarized in the following table and detailed below:

Project Description	Hardware	Software	Professional Fees	Total Capital
ADT RealTime Notification				
Original Budget	$0	$1,400,000	$100,000	$1,500,000
Reapportionment	$0	($500,000)	$500,000	$0
Revised Budget	$0	$900,000	$600,000	$1,500,000
Hospital Data Sharing System				
Original Budget	$0	$400,000	$606,250	$1,006,250
Reapportionment	$0	$500,000	($500,000)	$0
Revised Budget	$0	$900,000	$106,250	$1,006,250

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Fiscal Impact
The fiscal impact for the recommended action is budget neutral. If further budget reapportionment changes are needed before the completion of the capital projects, Management will return to the Board to request authorization.

Rationale for Recommendation
Staff recommends approval of the recommended action as a budget-neutral way to better align budgeted funds with anticipated expenditures on Capital Projects in accordance with the CalOptima Policy: GA.5003 Budget and Operations Forecasting.

Concurrence
Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachment
1. FY 2019-20 Capital Attachment A

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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Attachment A

Fiscal Year 2019-20 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Network	2,153,200	-	75,000	2,228,200
Upgrades/Replacements	325,000	118,000	5,000	448,000
Storage	225,000	25,000	5,000	255,000
Security	50,000	150,000	50,000	250,000
Disaster Recovery	-	-	-	-
TOTAL INFRASTRUCTURE	**$ 2,753,200**	**$ 293,000**	**$ 135,000**	**$ 3,181,200**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
ADT RealTime Notifications	-	1,400,000	100,000	1,500,000
Hospital Data Sharing System	-	400,000	606,250	1,006,250
Hierarchical Condition Category Risk Adjustment Factor	-	781,848	-	781,848
EHR System	-	500,000	32,500	532,500
Predictive Modeling	-	300,000	75,000	375,000
Telehealth	-	250,000	100,000	350,000
Credentialing Management	-	76,000	122,850	198,850
TOTAL APPLICATIONS MANAGEMENT	**$ -**	**$ 3,707,848**	**$ 1,036,600**	**$ 4,744,448**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Provider Portal Continuation	-	-	750,000	750,000
Alternative to Microsoft Access Operational Applications	50,000	15,000	500,000	565,000
Employee Learning Management System	-	110,000	25,000	135,000
Data Warehouse and Business Intelligence Governance and Catalog Tool	-	75,000	2,500	77,500
Threshold Language In Memory Translation Software	5,000	60,000	2,000	67,000
Vendor and Employee Exclusion Monitoring	-	30,000	-	30,000
Code Secure Software Veracode Static Analysis	-	24,000	-	24,000
Employee Emergency Notification System	-	10,000	2,000	12,000
Great Plains Accounting Automated Integration	-	5,000	1,000	6,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 55,000**	**$ 329,000**	**$ 1,282,500**	**$ 1,666,500**

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Main Cooling Tower Replacement	881,000	-	-	881,000
New Roof Membrane	200,000	-	-	200,000
Annual Xerox Capital Lease	125,000	-	-	125,000
Conference Room 910 Upgrades	25,000	-	-	25,000
Replace HVAC Unit for Intermediate Distribution Frame Room	25,000	-	-	25,000
Replace Magnetic Starters for Motor Control Center in Basement	25,000	-	-	25,000
Main Fire Line Replacement	25,000	-	-	25,000
Replace Conference Room Audio Visual Equipment	20,000	-	-	20,000
Security Cameras	20,000	-	-	20,000
6th Floor Lunchroom Remodel	13,000	-	-	13,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,359,000**	**$ -**	**$ -**	**$ 1,359,000**

PACE	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Food Service Kitchen	22,500	-	2,500	25,000
Dishwasher	11,000	-	-	11,000
Patio Upgrade	10,000	-	-	10,000
Electronic Patient Board	4,000	-	3,500	7,500
TOTAL PACE	**$ 47,500**	**$ -**	**$ 6,000**	**$ 53,500**

TOTAL FY19 NEW CAPITAL BUDGET	**$ 4,214,700**	**$ 4,329,848**	**$ 2,460,100**	**$ 11,004,648**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

19. Consider Authorizing Amendments to CalOptima's Coordination and Provision of Public Health Care Services and Coordination and Provision of Behavioral Healthcare Services Agreements with the Orange County Health Care Agency

Contacts

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

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's Coordination and Provision of Public Health Care Services and Coordination and Provision of Behavioral Healthcare Services agreements with the Orange County Health Care Agency (County) to include the Program of All-Inclusive Care for the Elderly (PACE) as a program

Background

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima opened its PACE Center on October 1, 2013, and currently serves approximately 394 members via the CalOptima PACE Center and five operating alternative care settings.

Operation of CalOptima's PACE site and alternative care settings is authorized through the PACE agreement between the Department of Health Care Services (DHCS) and CalOptima (DHCS PACE Agreement), as well as CalOptima's agreement with the Centers for Medicare & Medicaid Services (CMS). The DHCS PACE Agreement provides parameters for PACE site operations, including terms and conditions, and capitation payment rates. The current DHCS PACE Agreement authorized by the CalOptima Board of Directors on November 5, 2020, is effective January 1, 2021, through December 31, 2024, with capitation rates renewing on an annual basis.

Discussion

Pursuant to CMS's 2019 Final Rule, new provisions have been incorporated into the current DHCS PACE Agreement, including a requirement that managed care plans (including CalOptima) have subcontracts in place for certain services that are referred to the local health departments. These contracts are to identify the scope and responsibilities of both parties, billing and reimbursements, reporting responsibilities, and coordination of services, including exchange of member information. Services for which CalOptima is subject to this requirement include those related to sexually transmitted diseases, HIV counseling and testing, immunizations, and mental health services.

CalOptima has an existing agreement in place with the County of Orange for the sexually transmitted diseases, HIV counseling and testing, and immunizations services for its Medi-Cal program and has an existing agreement with the County for mental health services for its OneCare and OneCare Connect

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programs. To remain in compliance with the new provisions of the DHCS PACE Agreement, staff requests authority to amend the Coordination and Provision of Public Health Care Services and Coordination and Provision of Behavioral Health Care Services contracts to reflect PACE as an additional program under which these services are covered. The amendments will be effective the first day of the month following execution of the contract.

Fiscal Impact

The recommended action to amend the Coordination and Provision of Public Health Care Services Contract and Coordination and Provision of Behavioral Healthcare Services agreements with the County of Orange to include PACE as a program is a budgeted item with no additional fiscal impact anticipated. Management has included expenses associated with the amendment in the consolidated CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Authorizing amendments to the Coordination and Provision of Public Health Care Services and the Coordination and Provision of Behavioral Health Care Services contracts will ensure CalOptima is compliant with the new provisions and requirements of the current DHCS PACE Agreement.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Previous Board Action dated November 5, 2020: "Consider Authorizing and Directing Execution of a New Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly."

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Authorizing and Directing Execution of a New Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 347-3261
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute a new Agreement for the Program of All-Inclusive Care for the Elderly (PACE) between the California Department of Health Care Services (DHCS) and CalOptima with a contract termination date through December 31, 2024, with the DHCS capitation rates renewed on a calendar year basis and changes in the contract terms that align with the 2019 Final Rule and Medi-Cal Managed Care Plan contract template.

Background

Since October 2009, the CalOptima Board has taken numerous actions related to the CalOptima PACE program. On June 6, 2013, the Board authorized the execution of the PACE Agreement between DHCS and CalOptima (DHCS PACE Agreement) as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. Beginning in September 2015 and thereafter, the Board has authorized execution of various amendments to the DHCS PACE Agreement for calendar year (CY) payment rates and other provisions, as summarized in the attached Appendix.

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide PACE participants with health care services, with the capitation rates renewed on a CY basis. The current DHCS PACE Agreement expires on December 31, 2020.

Discussion

On August 26, 2020, DHCS provided CalOptima with a final redline version of the new DHCS PACE Agreement that replaces the current contract and all its amendments in its entirety. By way of background, from June 2019 through August 2020, DHCS was in the process of reviewing all the feedback and comments it had received from stakeholders. On June 21, 2019, DHCS released the initial draft version of a new template for the DHCS PACE Agreement for an opportunity to comment on the proposed changes. CalOptima staff submitted feedback, as did the CalPACE Association and other PACE organizations operating in other parts of the State. DHCS referred to this process as the "Contract Overhaul", instead of adding on subsequent Amendments to the existing DHCS PACE Agreement.

In June 2020, an Amendment was authorized to extend the current DHCS PACE Agreement through December 31, 2020, and CalOptima staff committed to return to the Board once the final Agreement was available, after DHCS vetted proposed changes with stakeholders was complete.

The new DHCS PACE Agreement will be:

- Effective January 1, 2021;
- Extend the contract termination date through December 31, 2024, with the DHCS capitation rates renewed on a CY basis; and
- Increase the maximum amount payable to accommodate the new term of the contract.

Summary of Language Updates

The following table summarizes the redline changes for the new DHCS PACE Agreement, in Appendix 2 for this Agenda item. The updates are intended to:

- Align the PACE contracts to conform provisions to those contained in the Managed Care Plan (MCP) *Medi-Cal* contracts; and
- Align PACE contracts with the 2019 PACE Final Rule issued by CMS last year.

CalOptima staff notes that while the volume of redlines are substantial throughout the various Exhibits, the redlined provisions in large part are not necessarily new regulatory requirements. CalOptima PACE is already in compliance with several of the "new" provisions. Examples of new provisions that are already met through current practices include mandated sensitivity training, monitoring of excluded individuals, and continuous Provider Training. The impact of new provisions that staff will address prior to the contract effective date mainly impact financial reporting and revising policy language. Nonetheless, all new provisions are outlined in the DHCS PACE Agreement.

Category	Type of Update	Update
General Change	Clarification language	Incorporates references throughout contract to various All Plan Letter (APLs) that is guidance for Medi-Cal MCPs. Updates references throughout the contract to point to current Code of Federal Regulations (CFRs), Title 28 - Health & Safety Code California Code of Regulations (CCRs), Title 22 CCRs, and Welfare & Institutions Code (WIC).
Exhibit A – Scope of Work		
Att. 1 - Organization and Administration of the Plan	Clarification language & new provisions	For conflict of interest, defines 5% or more as the threshold for triggering an updated Key Personnel Disclosure form, in addition to an annual filing. New provision to provide current organizational chart. New individual provision to reinforce medical decisions, including those by Sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management. Further elaborates on the provision to ensure monitoring that excluded individuals are not employed or contracted. New provision on Sensitivity Training. New provision noting DHCS reserves the right to conduct audits of mature PACE Organizations outside of the joint CMS audit(s).

Category	Type of Update	Update
		New provision on Oversight and Enforcement Authority, including corrective action plans, withholding of payments, sanctions and termination of contract.
Att. 2 - Financial Information	Clarification language & new provisions	Modifies timing of Financial Audit Report submission to 180 days (instead of 120) after the close of PACE's fiscal year. Eliminates provision on "*Line of Business Data Reporting & Financial Statements*". Modifies timing of Annual Forecasts to 60 days prior to the beginning of a new Fiscal year (instead of 30 days following the FY). New provision to prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the Department of Managed Health Care (DMHC) required financial reporting format.
Att. 3 - Management Information System	Clarification language & new provisions	Clarifies Encounter Data shall be submitted on at least a monthly basis in a form and manner specified by DHCS, and allows submission on a more frequent basis if preferable. New provision specifying DHCS will measure the quality of the Encounter Data for completeness, timeliness, reasonability, and accuracy.
Att. 4 - Quality Improvement Systems	Clarification language & new provisions	Modifies timing of submission of Quality Improvement report, from the end of the PACE fiscal year to on an annual basis. New provision on ensuring all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Eliminates requirement for PACE providers to also be Medi-Cal enrolled. New provision to maintain member dental records and implement a system to review dental records.
Att. 5 - Utilization Management (UM)	Clarification language & new provisions	New provision specifying additional details for UM Program. New provision specifying additional details for Timeframes for different types of Medical Authorizations (Emergency, Non-Urgent, Concurrent review, Retrospective review, Pharmaceuticals, Routine, Expedited and Hospice Inpatient Care).
Att. 6 - Provider Network	Clarification language & new provisions	New provision specifying PACE shall ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and PACE Centers within each service area. New Provision specifying a designated emergency service facility, providing care on a 24 hours a day, seven days-per-

Category	Type of Update	Update
		week basis. This designated emergency service facility will have one or more Physicians and one or more nurses on duty in the facility at all times. New provision for PACE to meet federal requirements for access to Federally Qualified Health Center (FQHC) services. For quarterly updated subcontractor listing, PACE shall notify DHCS in the event the agreement with the Subcontractor is amended or terminated. Further elaborates on Subcontract requirements.
Att.7 - Provider Relations	Clarification language & new provisions	Further elaborates on Provider Manual requirements, including specific Member Rights, Grievance and Appeals and State Hearing information. Modifies the timing of Provider's PACE Training requirement to take place prior to commencement of services to Participants (instead of within 10 working days after contracting). New provision for a process to provide Provider Training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for SPDs or persons with chronic conditions.
Att. 8 - Provider Compensation Arrangements	Clarification language & new provisions	Modifies the compensation provision for subcontractors to allow it to be determined by a percentage of the payment from DHCS, unless DHCS objects, as well as by negotiation that the Provider and Contractor agree to. Modifies Claims Processing provisions to provide clarification. New provisions regarding reimbursements to FQHCs, Rural Health Clinics (RHC) and Indian Health Programs. Further elaborates on Post-Stabilization Services and requires PACE to establish and maintain a written plan which provides for coverage of urgently needed out-of-network and post-stabilization care services when certain criteria is met. Also clarifies the Medi-Cal payment amounts for post-stabilization services.
Att. 9 - Access and Availability	Clarification language & new provisions	New provisions to clarify and reinforce PACE-covered benefits of comprehensive medical, health, and social services that integrate acute and long-term care, and the requirement to have a written plan for each member (referred to as "plan of care" or "individual care plan"). New provision regarding ensuring telehealth is available and certain criteria is met. New provision for PACE to communicate, enforce, and monitor providers' compliance with these requirements.

Category	Type of Update	Update
		New provision for PACE to include procedures for follow-up on missed appointments. New provision specifying additional details for Emergency Care. Modifies timing of requirement to notify DHCS of changes in PACE Center location to 180 calendar days prior to effective date of changes (previously 30 days). Updates provisions for Nondiscrimination and Language Access. Updates provisions for Linguistic Services (oral & American Sign Language interpreters, TTY, translated materials). Eliminates provision on "*Healthcare Surge Events"*, which is now covered under the Emergency Preparedness Plan requirements. New provision to reinforce the use of out-of-network providers if PACE is unable to provide necessary covered services.
Att. 10 - Scope of Services	Clarification language & new provisions	New provision specifying that Medi-Cal benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply. Further elaborates on Immunization requirements. Modifies for clarification and additional specificity the Services for All Members: A. Health Education (makes health categories and topics more generalized) a. risk-reduction and healthy lifestyles; tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV; nutrition, weight control, and physical activity; and b. self-care and management of health conditions: asthma, diabetes; and hypertension. - PACE to cover and ensure provision of Comprehensive Case Management including coordination of care services B. Nursing Facility Services C. Vision Care: Lenses D. Mental Health Services E. Tuberculosis F. Pharmaceutical Services and Provision of Prescribed Drugs G. Transportation Services (New provision) H. Dietary Services (New provision)

Category	Type of Update	Update
Att.11 - Case Management and Coordination of Care	Clarification language & new provisions	New provision on Out-of-Plan Case Management and Coordination of Care New provision on Immunization Registry Reporting to be made following the Member's IHA and all other health care visits which result in an immunization being provided. New provision on the exclusion of Erectile Dysfunction (ED) Drugs and Other ED Therapies, unless such drug is used to treat a condition other than sexual or erectile dysfunction, and as approved by the Food and Drug Administration. ED drugs and other ED therapies are covered if they are determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.
Att. 12 - Local Health Department Coordination	Clarification language & new provisions	New Exhibit with provisions for Local Health Department Coordination for various types of services, referrals, and/or reporting: - STD services - HIV testing & counseling - Immunizations - Medi-Cal Mental Health Plan coordination
Att. 13 - Member Services	Clarification language & new provisions	Updates provisions for Member Rights & Responsibilities/ Participant Bill of Rights. New provision on Limiting use of Restraints. New provision on training program for PACE Staff and defines specific criteria for staff that has direct participant contact. New provisions specifying further details on requirements for written information: Definition, font size, reading-level, threshold languages, alternative format, disclaimers. Modifies the information that must be contained in the Member Enrollment/Terms and Conditions (increased from 26 to 30 elements).
Att. 14 - Member Grievance and Appeals	Clarification language & new provisions	New provision to include definition of a grievance and elaborate on the minimum requirements for process, notification, resolution and analyzing grievance information. New provision on handling Discrimination Grievances. Updates provisions on Member Notification of Denial, Deferral or Modification of Request for Prior Authorization, and Appeals.
Att. 15 - Marketing	Clarification language & new provisions	New provisions specifying additional details on Marketing and Prohibited Marketing Practices (aligning with CMS marketing guidance). Eliminate the provision that defines the elements of the Marketing Plan (PACE must still have a plan and submit to DHCS for approval, but no longer outlines the composition of the plan).

Category	Type of Update	Update
Att. 16 - Enrollments and Disenrollments	Clarification language & new provisions	New provision to delineate eligibility criteria and other eligibility requirements. Modifies for clarification and additional specificity the provisions on enrollment, disenrollment and information to Prospective participants. New provisions for distinguishing between Voluntary and Involuntary Disenrollment, and the process/timing requirements for each.
Att. 17 - Reporting Requirements	Clarification language & new provisions	New provision to report Inpatient Days information, within 30 calendar days of receipt of DHCS' written request.
Exhibit B - Budget Detail and Payment Revisions		
Budget Detail and Payment Provisions	Clarification language & new provisions	New provision on Amounts Payable. Updates provision on Capitation Rates for clarity on the amount specified and the schedule of payment. Updates the provision on Capitation Rates Constitute Payment in Full to modify the definition. New provision on Financial Performance Guarantee. New provision for Recovery of Capitation Payments related to retroactive disenrollment of Participants. Eliminates the provision related to improper or erroneous AIDS claim payments.
Att.1- Rate of Medi-Cal Reimbursements	Clarification language & new provisions	No changes. This Attachment is updated annually with new capitation payment rate information based on Medi-Cal Aid Code categories.
Exhibit E		
Att. 1 - Definitions	Clarification language & new provisions	Updates Definitions to incorporate new terms and modify some of the existing terms.
Att. 2 - Program Terms and Conditions	Clarification language & new provisions	Updates provision on Certifications requirements. Modifies the provision on Termination for Cause and Other Terminations to clarify and elaborate on criteria and timing. Modifies the provision on Notice to Members of Transfer of Care to specify a 60 day requirement prior to the proposed termination date to submit a detailed written plan for phase down to DHCS for approval prior to implementation. New provisions related to Phaseout Requirements for payment and activities. New provision to further elaborate on Sanctions provisions. New provision on Liquidated Damages to replace the former provision on Professional Review System.

Category	Type of Update	Update
		Updates the provisions on Notification of Dispute and Contracting Officer's or Alternate Dispute Officer's Decision for clarification. Modifies the Records Retention provision to increase the requirement to ten years (up from six). Updates the provision on Inspection Rights to incorporate references to the Department of Justice, Bureau of Medi-Cal Fraud, and Department of Managed Health Care. New provision that allows participation in Pilot Projects. New provisions on Fraud and Abuse Reporting, establishing an Anti-Fraud and Abuse Program and Tracking Suspended Providers. Updates the provision on Discrimination Prohibitions to specify the applicable categories it applies to. Updates the provision on Additional Federal Requirements, formerly specific to the Americans with Disabilities Act of 1990. New provision to incorporate the Federal False Claims Act Compliance. Eliminates provisions on Program Information, Compliance with Protocols and Reimbursement and Operations Reliance, that are further clarified and included elsewhere in the contract. Updates provision on Payment for Services, to incorporate actuarily sound capitation rates. Updates provision on Medical Review to further elaborate on DHCS' discretion authority, to eliminate duplication of auditing efforts.
Exhibit G		
HIPAA Business Associate Addendum	Replaced	Exhibit G, Attachment A, Health Insurance Portability and Accountability Act (HIPAA) of the contract has been replaced by Exhibit G, Business Associate Addendum.

Fiscal Impact

The recommended action to execute a new PACE Agreement between DHCS and CalOptima with a contract termination date through December 31, 2024, is a budgeted item, with no additional fiscal impact through June 30, 2021~~2020~~. The CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020, incorporated draft CY 2020 and forecasted CY 2021 PACE capitation rates. Management will include funding for the period of July 1, 2021~~2020~~, through December 31, 2024, in future operating budgets.

Rev. 11/5/20

Rationale for Recommendation

CalOptima's execution of the new DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Appendix Summary of Amendments to PACE Primary Agreements
2. DHCS PACE Complete Overhaul Contract – Final Redline
3. Exhibit G HIPAA Addendum

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 5

The following is a summary of amendments to the PACE Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	December 7, 2017
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017

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Amendments to Primary Agreement with DHCS	Board Approval
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	December 5, 2019
A10 provided an extension of the contract termination date to December 31, 2020 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2020 for the period of January 1, 2020 through December 31, 2020.	June 4, 2020
New Primary Agreement: Replaces the previous contract and subsequent amendments in their entirety, effective January 1, 2021. Also extends the contract termination date to December 31, 2024, with DHCS capitation rates renewed on a calendar year basis. The new agreement aligns the PACE DHCS agreement with: • provisions contained in the Managed Care Plan (MCP) Medi-Cal contracts; and • provisions in the CMS 2019 Final Rule.	**Pending**
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

Exhibit A, Attachment 1
Organization and Administration of the Plan

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHCS and maintain all appropriate licenses, as determined by and at the sole discretion of DHCS, to operate a Program of All-Inclusive Care for the Elderly (PACE).

If Contractor does not operate a primary care clinic licensed to operate by the California Department of Public Health pursuant to California ~~Health and Safety~~ Code**,** section 1204, et seq., then Contractor must operate its primary care clinic in accordance with all requirements applicable to the operation of licensed ~~p~~**P**rimary ~~c~~**C**are clinics, subject to oversight and approval of the ~~Department of Health Care Services~~ **DHCS**. If Contractor fails to comply with the requirements for operation of a licensed primary care clinic, the ~~Department of Health Care Services~~ **DHCS** may require Contractor to submit a Corrective Action Plan **(CAP)**. If Contractor does not carry out the ~~Corrective Action Plan~~ **CAP** to comply with the requirements for operation of a licensed primary care clinic, the ~~Department of Health Care Services~~ **DHCS** may terminate this contract.

2. Key Personnel**:** Disclosure ~~Statement~~ Form

A. Contractor shall file an annual statement with ~~the~~ DHCS disclosing any purchases or leases of services, equipment, supplies or real property from an entity in which any of the following persons have a substantial financial interest:

1) ~~A~~**a**ny person ~~also~~ **or corporation** having **5% or more ownership or controlling** a substantial financial interest in Contractor**;**

2) ~~A~~**a**ny director, officer, partner, trustee**,** or employee of Contractor**; or**

3) ~~A~~**a**ny immediate family member of any person designated in (1) or (2) above.

Contractor shall ensure that individuals on ~~the organization's~~ **its** governing body, and their family members comply with conflict of interest requirement**s** specified in ~~42 Code of Federal Regulations (CFR)~~ **42 CFR,** Section 460.68(b) **and Welfare & Institutions Code Sections 14030, 14031, and 14032.**

B. Organizational Chart

Exhibit A, Attachment 1
Organization and Administration of the Plan

1) Contractor shall provide DHCS with a current organizational chart showing officials in the PACE organization and relationships to any other organizational entities. The organizational chart shall show where the Contractor PACE Organization relates to the other entities and the reporting structure from the governing body to the Contractor PACE organization.

2) The chart for a corporate entity must indicate the Contractor's relationship to the corporate board and to any parent, affiliate, or subsidiary corporate entities.

3) If Contractor is planning a change in organizational structure, it must notify DHCS, in writing, at least 14 days before the change takes effect.

3. Conflict of Interest: Current ~~A~~and Former State Employees

Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official **whose employment with the State in any way involves or is related to the operation, oversight, approval, contracting or establishment of PACE plans,** unless the employment, activity or enterprise is required as a condition of the officer's or employee's regular state employment. **For purposes of this subsection only, ~~E~~e**mployee in the State civil service ~~is defined to be~~ **means** any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract **in accordance with Title 28, CCR, Section 1300.67.3 (28 CCR 1300.67.3) and Title 22 CCR Sections 53800, 53851 and 53857**. Contractor shall ensure the following:

A. ~~The organization~~ **Contractor** has an accountable governing body with full legal authority and responsibility, as required in 42 CFR, Section 460.62(a).

B. This Contract is a high priority and ~~that the~~ Contractor is committed to supplying necessary resources to assure full performance of the Contract.

Exhibit A, Attachment 1
Organization and Administration of the Plan

C. If ~~the~~ Contractor is a subsidiary ~~organization~~, the attestation of the parent organization that this Contract shall be a high priority to the parent ~~organization~~, and that the parent ~~organization~~ is committed to supplying any **and all** necessary resources to assure full performance of the Contract.

D. ~~A~~ **Contractor has a** full-time Program Director ~~to administer the day-to-day business activities of Contractor~~ **who is responsible for the oversight and administration of the PACE plan, as required by 42 CFR 460.60**.

E. **Contractor has** ~~S~~**s**ufficient support staff to conduct Contractor's daily business in an orderly manner, as determined through management, medical, dental, and fiscal reviews **conducted or requested by DHCS**.

F. ~~Participant~~ **Contractor's** representation on the ~~G~~**g**overning body ~~is required on~~ **includes a member representative when** issues related to ~~Participant~~ **member** care, ~~pursuant to~~ **are under consideration, as required by** 42 CFR, Section 460.62(c).

G. **Contractor has** ~~Establishment of~~ **established** a ~~p~~**P**articipant advisory committee, ~~pursuant to~~ **as required by** 42 CFR~~, Section~~ 460.62(b).

H. If Contractor is planning ~~a change in the~~ **to change its** organizational structure, written notification **describing that change** must be provided to ~~the~~ DHCS, at least 14 days before the change would take effect, ~~for approval~~ **in order to obtain DHCS approval to continue this contract under the new organizational structure in compliance with Medi-Cal and Medicaid laws and regulations**.

I. Contractor shall:

1) collect data;

2) maintain, and afford DHCS access to, the records relating to the program, including pertinent financial, medical, and personnel records;

3) make available to DHCS reports that DHCS considers necessary to monitor the operation, cost, and effectiveness of the PACE program;

4) during the first 3 years of operation of a PACE program, provide such additional data as DHCS specifies in order to

perform the oversight required during the initial 3 year trial period;

5) maintain records and report data in compliance with 42 U.S.C. Section 1395eee(e)(3) and 42 CFR 460.32(a)(11), 460.202, 460.204, 460.208, and 460.210.

J. Contractor shall meet all applicable requirements under Federal, State, and local laws and regulations, including Section 1557 of the Affordable Care Act, the Civil Rights Act, the Age Discrimination Act, Section 504 of the Rehabilitation Act, the Americans With Disabilities Act, and Section 11135 of the Government Code.

5. Medical Decisions

Contractor shall ensure that medical decisions, including those by Sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.

5~~6~~6. Program Director

Contractor shall maintain a full-time Program Director who**se duties include,** ~~shall assume~~, but **may** not be limited to, the following responsibilities:

A. Ensur**ing** oversight and administration within the organization~~.~~**;**

B. Ensur**ing** that **decisions concerning** medical, social, and supportive services decisions are not unduly influenced by fiscal or administrative management~~.~~**;**

C. Ensur**ing** that appropriate personnel perform their functions within the organization~~.~~**; and**

D. Inform**ing** employees and contracted providers of applicable organization policies and procedures.

~~6~~7. Medical Director

Contractor shall maintain a **full time** ~~P~~**p**hysician as Medical Director**, in compliance with 42 CFR section 460.60,** ~~who shall assume the following responsibilities~~ **whose responsibilities shall include, but not be limited to, the following**:

Exhibit A, Attachment 1
Organization and Administration of the Plan

A. Ensuring that medical decisions are:

1) rendered by qualified medical personnel; and

2) are not unduly influenced by fiscal or administrative management considerations;

~~A~~**B**. ~~E~~**e**nsur**ing** that **provided** medical care ~~provided~~ meets **or exceeds** the standards for acceptable medical care~~.~~**;**

~~B~~**C**. ~~E~~**e**nsur**ing** that medical protocols and rules of conduct for plan medical personnel are followed~~.~~**;**

~~C~~**D**. ~~D~~**d**develop**ing** and implement**ing** medical policy~~.~~**;**

~~D~~**E**. ~~R~~**r**esolv**ing** ~~medically related G~~**g**rievances **related to quality of medical care**~~.~~**;**

~~E~~**F**. ~~Have a significant role in Contractor's Quality Improvement System (QIS)~~ **actively participating in Contractor's grievance procedures; and**

~~F~~**G**. ~~Have a significant role in Contractor's Quality Improvement System (QIS)~~ **actively participating in the implementation of Quality Improvement (QI) activities**.

~~G. Achieve the best clinical outcomes possible for all Members.~~

~~H. Ensure medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations.~~

~~7~~8. Medical Director Changes

Contractor shall report to DHCS any changes in the status of the Medical Director within ~~10~~ **ten calendar** days.

~~8~~9. Administrative Duties/Responsibilities

Contractor shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Contract. This shall include, at a minimum, the following:

Exhibit A, Attachment 1
Organization and Administration of the Plan

A. ~~E~~**e**nsur**ing** personnel meet all **applicable** ~~S~~**s**tate licensure, certification, or registration requirements~~.~~**;**

B. ~~Ensure~~ **providing** on-going training, ~~pursuant to~~ **as required by** 42 CFR, Section 460.66(a)~~.~~**;**

C. ~~E~~**e**nsur**ing** patient safety and to achieve patient-specific performance measures requiring actions necessary of each staff member (employee**s** and contractors) to address different medical and non-medical emergencies~~.~~**;**

D. Ensuring Contractor does not employ or contract with organizations or individuals:

1) who have been excluded from participation in the Medicare or Medicaid programs;

2) who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act;

3) If the PACE organization determines that an individual's contact with participants would pose a potential risk because the individual has been convicted of one or more criminal offenses related to physical, sexual, drug, or alcohol abuse, or use;

4) who have been found guilty of abusing, neglecting, or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property; or

5) who have been convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act.

Contractor shall have a formal process in place to gather information related to this paragraph and shall respond in writing to a request for information from DHCS within a reasonable amount of time.

Exhibit A, Attachment 1
Organization and Administration of the Plan

Contractor shall comply with the requirements of 42 CFR 460.86 regarding payment to individuals and entities excluded by the Office of the Inspector General or included on the preclusion list.

~~D. Contractor does not employ any staff (employees or contractors) who have been convicted of criminal offenses, pursuant to 42 CFR, Section 460.68(a).~~

E. Designat**ing** persons qualified by training or experience, to be responsible for the Medical Record service~~.~~**;**

F. **establishing and maintaining M**~~m~~ember **E**~~e~~nrollment and Disenrollment reporting systems**.**

G. **establishing and maintaining m**ember **g**rievance and **a**ppeals procedures**, as specified in Exhibit A, Attachment 14.**

H. **establishing and maintaining d**ata reporting capabilities sufficient to provide necessary and timely reports to DHCS**, as required in Exhibit A, Attachment 3, and elsewhere in this contract.**

I. **maintaining f**inancial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully disclose**s** the disposition of all Medi-Cal program funds received**, as specified in Exhibit A, Attachment 2.**

J. **establishing and maintaining c**laims processing capabilities **as described in Exhibit A, Attachment 8.**

K. Maintaining and affording DHCS access to the records relating to the program, including pertinent financial, medical, and personnel records.

L. Making available to DHCS reports that DHCS finds necessary to monitor the operation, cost, and effectiveness of the PACE program.

M. Cooperating with DHCS in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

N. Identifying members of Contractor's governing body or any immediate family member having a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE organization.

Exhibit A, Attachment 1
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1) Contractor shall develop policies and procedures for handling any direct or indirect conflict of interest by a member of the governing body or by the member's immediate family.

2) In the event of a direct or indirect conflict of interest by a member of Contractor's governing body or his or her immediate family member, the board member must—

   a. Fully disclose the exact nature of the conflict to the board of directors and have the disclosure documented; and

   b. Recuse himself or herself from discussing, negotiating, or voting on any issue or contract that could result in an inappropriate conflict.

3) Contractor shall have a formal process in place to gather information related to this paragraph and must be able to respond in writing to a request for information from CMS and/or DHCS within a reasonable amount of time.

10. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD) and persons with chronic conditions (such as asthma, diabetes, and congestive heart failure), are represented and participate in establishing public policy within the Contractor's Participant Advisory Committee.

11. Sensitivity Training

Contractor shall ensure that all personnel who interact with beneficiaries, as well as those who may potentially interact with beneficiaries, and any other staff deemed appropriate by Contractor or DHCS, shall receive sensitivity training.

12. Contract Oversight During Trial Period

Contractor shall be subject to annual, close oversight during the trial period, meaning the first 3 contract years as a PACE provider, as set forth in 42 U.S.C. Section 1496eee(e)(4) and 42 CFR 460.190. During the trial period, CMS and DHCS conduct a comprehensive annual review of the operation of Contractor's PACE program in order to assure compliance with the legal and contractual requirements. Such a review shall include--

Exhibit A, Attachment 1
Organization and Administration of the Plan

A. an on-site visit to the program site;

B. comprehensive assessment of Contractor's fiscal soundness;

C. comprehensive assessment of Contractor's capacity to provide all PACE services to all enrolled members;

D. detailed analysis of Contractor's substantial compliance with all significant requirements of federal and state law and regulations; and

E. any other elements the Secretary or DHCS considers necessary or appropriate.

After the trial period, CMS in cooperation with DHCS will continue to conduct such review of the operation of Contractor and its PACE program as may be appropriate, taking into account Contractor's performance level and compliance with all significant requirements of law and regulations pursuant to 42 CFR 460.192

DHCS reserves the right to conduct audits of mature PACE Organizations outside of the joint CMS audit(s) as described above. This requirement is to ensure that all PACE Organizations comply with current state requirements along with contractual deliverables. The audits shall include but not limited to: an on-site visit at least every 3 years or as appropriate to address program deliverables, monitoring and oversight activities ensuring program compliance. The results of these reviews will be reported promptly to Contractor, along with any recommendations for changes to the Contractor's program, audit findings may be posted online to provide transparency.

As described in 42 CFR 460.194, Contractor must take action to correct deficiencies identified during reviews. CMS and/or DHCS monitors the effectiveness of the corrective actions. Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results is governed by 42 CFR 460.196.

13. Oversight and Enforcement Authority

A. In general

If it is determined by DHCS or the Centers for Medicare and Medicaid Services (CMS) that Contractor is failing substantially to comply with the requirements of federal or state laws or regulations, CMS and DHCS may take any or all of the following actions:

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Exhibit A, Attachment 1
Organization and Administration of the Plan

1) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

2) Withhold some or all further payments under the PACE program agreement under 42 USC Section 1395eee(e)(6) or Section 1396u-4 with respect to PACE program services furnished by Contractor until the deficiencies have been corrected.

3) Terminate such agreement.

B. Application of intermediate sanctions

CMS may provide for the application against Contractor of remedies described in section 42 USC Sections 1395w-27(g)(2) or 1396b(m)(5)(B in the case of violations by the Contractor of the type described in sections 1395w-27(g)(1) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under this section or section 1396u-4, respectively).

C. DHCS Actions

DHCS may take enforcement action with respect to Contractor as described in Welfare & Institutions Code Section 14304.

Exhibit A, Attachment 2
Financial Information

1. Financial Viability/Standards Compliance

Contractor shall **comply with the requirements of 42 CFR 460.80, and** meet and maintain financial viability/standards compliance to DHCS' satisfaction for each of the following elements**.** ~~:~~ **To the extent that there is any conflict between State and federal law, or between this contract and federal law, the stricter of the requirements shall apply.**

A. Tangible Net Equity (TNE)

Contractor **at all times** shall ~~maintain a~~ **be in compliance with the** TNE ~~equal to one month's Capitation~~ **requirements 28, CCR, Section 1300.76**.

B. Administrative Costs

Contractor's ~~A~~**a**dministrative ~~C~~**c**osts shall not exceed the standards ~~as~~ established under Title 2~~2~~**8**, CCR, Section ~~53864(b)~~ **1300.78**.

C. Standards of Organization and Financial Soundness

Contractor shall provide, and update as changes occur, a description of its organizational structure and information on administrative contacts including the following;

1) name and phone number of the program director;

2) name of all governing body members; and

3) name and phone number of a contact person for the governing body.

~~1)~~ Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and ~~Cal. Code Regs., tit.~~Title 22 **CCR** ~~s~~**S**ections 53851, ~~53863,~~ and 53864.

~~2) If the organization conducting the day-to-day operations of the program is a subsidiary entity within a larger parent company, a separation of duties must be clearly established between the two entities in Contractor's operating policies and procedures and in its financial record keeping. A separate financial statement must be~~

~~maintained for this entity, which includes but is not limited to the balance and income statements. The financial reserve requirements specified in Exhibit B, Budget Detail and Payment Provisions, provision 10. Financial Performance Guarantee must be held in a separate bank account clearly designated as the specific program reserve account. The funds in this account shall not be commingled with the reserves for any other program.~~

~~D. Working capital and current ratio of one of the following:~~

~~1) Contractor shall maintain a working capital ratio of at least 1:1; or~~

~~2) Contractor shall demonstrate to DHCS that Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or~~

~~3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.~~

2. Financial Audit ~~/~~ Reports

Contractor shall ensure that an annual audit is performed ~~according to the Welfare and Institutions (W&I) Code, Section 14459~~. **A financial statement, audited by a** Certified Public Accountant~~'s~~ (CPA) ~~audited Financial Statements~~ shall be submitted to DHCS no later than ~~120~~ **180** calendar days after the close of the Contractor's fiscal year. Combined ~~F~~**f**inancial ~~S~~**s**tatements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services ~~is~~ **are** dependent upon Affiliates. Financial ~~S~~**s**tatements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. Contractor shall have separate certified ~~F~~**f**inancial ~~S~~**s**tatements prepared if an independent accountant decides that preparation of combined statements is inappropriate.

A. The independent accountant shall state in writing reasons for not preparing combined ~~F~~**f**inancial ~~S~~**s**tatements.

B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to

analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified ~~F~~**f**inancial ~~S~~**s**tatements Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The CPA audited ~~F~~**f**inancial ~~S~~**s**tatements and **the** DMHC required financial reporting forms shall be submitted to DHCS no later than ~~120~~ **180** calendar days after the close of Contractor's Fiscal Year **(FY)**.

2) If Contractor is a public entity or a political subdivision of the ~~S~~**s**tate and a county grand jury conducts Contractor's financial audits, Contractor shall submit its financial statement within 180 calendar days after the close of ~~Contractor's Fiscal Year~~ **the FY** in accordance with Health and Safety Code, section 1384.

3) Contractor shall submit to DHCS within 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports required by Title 22~~,~~ CCR~~,~~ Section 53862(b)(1). The required quarterly financial reports shall be prepared on DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

   a. Jurat**;**

   b. Report 1A and 1B: Balance Sheet**;**

   c. Report 2: Statement of Revenue, Expenses, and Net Worth**;**

   d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for GAAP compliance)**;**

   e. Report 4: Enrollment and Utilization Table**;**

   f. Schedule F: Unpaid Claims Analysis**;**

   g. Appropriate footnote disclosures in accordance with GAAP**; and**

   h. Schedule H: Aging Of All Claims.

Exhibit A, Attachment 2
Financial Information

C. Contractor shall authorize the independent accountant to allow ~~representatives of~~ DHCS **designated representatives or agents**, upon written request, to inspect any and all working papers related to the preparation of the audit report.

D. Contractor shall submit to DHCS all financial reports relevant to Affiliates as specified in Title 22~~,~~ CCR~~,~~ Section 53330(a)(1) **and 53862(c)(4)**.

E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53324(d).

3. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly ~~F~~**f**inancial ~~S~~**s**tatements with the ~~California Department of Managed Health Care (~~DMHC~~)~~, Contractor and/or subcontractor shall file an exact copy of the monthly ~~F~~**f**inancial ~~S~~**s**tatements with DHCS. Contractor and/or subcontractor shall submit monthly financial statements to DHCS upon request, if deemed necessary, to monitor the Contractor and/or subcontractor's financial viability.

Contractor shall submit to DHCS no later than 30 calendar days after the close of Contractor's fiscal month, monthly financial reports in accordance with Title 22~~,~~ CCR~~,~~ Section 53862(c)(6). Monthly financial reports shall be prepared on the DMHC- required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat**;**

B. Report 1A and 1B: Balance Sheet**;**

C. Report 2: Statement of Revenue, Expenses, and Net Worth**;**

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for ~~Generally Accepted Accounting Principles (~~GAAP~~)~~ compliance~~.~~)**;**

E. Report 4: Enrollment and Utilization Table**;**

F. Schedule F: Unpaid Claims Analysis**;**

Exhibit A, Attachment 2
Financial Information

G. ~~A~~**a**ppropriate footnote disclosures in accordance with GAAP**; and**

H. Schedule H: Aging of All Claims.

4. Annual Financial Statements

Contractor shall submit to DHCS no later than ~~120~~ **180** calendar days after the close of Contractor's fiscal year, annual financial reports. Contractor's annual financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat**;**

B. Report 1A and 1B: Balance Sheet**;**

C. Report 2: Statement of Revenue, Expenses, and Net Worth**;**

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for ~~Generally Accepted Accounting Principles (~~GAAP~~)~~ compliance~~.~~)**;**

E. Report 4: Enrollment and Utilization Table**;**

F. Schedule F: Unpaid Claims Analysis**;**

G. ~~A~~**a**ppropriate footnote disclosures in accordance with GAAP**; and**

H. Schedule H: Aging of All Claims.

~~**5. Line of Business Data Reporting and Financial Statements**~~

~~Contractor shall prepare and submit the PACE Utilization Report and PACE Line of Business Report on a semi-annual basis. These reports shall include, at a minimum, the following:~~

~~A. PACE Utilization Report: Cumulative statement of utilization by each service category and funding source over a 6 month period.~~

~~B. PACE Line of Business Report: This report shall be used to translate enrollee utilization to financial reporting along all revenue/expense streams. The Contractor shall use this report to track the total revenue for~~

~~each funding source as well as the expenses paid out for each PACE service category and general administrative costs.~~

~~C. Contractor shall submit these reports no later than 45 calendar days following the end of the six month period.~~

~~6~~5. Annual Forecasts

~~Contractor shall submit to DHCS no later than 30 calendar days following the beginning of Contractor's fiscal year, an annual forecast for Contractor's next fiscal year. Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:~~

Contractor shall submit to DHCS at least 60 days prior to the beginning of the FY, an annual forecast for the next FY.

Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Report 2: Statement of Revenue, Expenses, and Net Worth by County. (Medi-Cal line of business)**;**

B. Report 4: Enrollment and Utilization Table by County. (Medi-Cal line of business)**;**

C. TNE (All lines of business)**; and**

D. ~~A~~**a** detailed explanation of all underlying assumptions used to develop the forecast.

~~7~~6. Compliance with Audit Requirements

Contractor shall cooperate with ~~DHCS'~~ audits **by DHCS, CMS, and any of their related entities or agents**. Such audits may be waived**, but is not required to be waived, by the auditing entity** upon submission of the financial audit for the same period conducted by DMHC pursuant to Health and Safety Code section 1382.

Exhibit A, Attachment 2
Financial Information

~~8~~7. Submittal of Financial Information

A. Contractor shall prepare financial information~~, including financial statements and projections/forecasts~~ requested in accordance with GAAP. **Where financial statements and projections/forecasts are requested,** ~~T~~**t**hese statements and projections/forecasts should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions ~~F~~**f**ormat. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or subcontractors shall submit financial information consistent with filing requirements of t~~he~~ DMHC unless otherwise specified by DHCS.

B. Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in DMHC required financial reporting format.

~~9~~8. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all risk bearing subcontracting provider groups including, but not limited to, HMOs, independent ~~physician~~**Physician**/provider associations (IPAs), medical groups, and Federally Qualified Health Centers **(FQHCs)**.

~~10~~9. Contractor's Obligations

Contractor is required under the terms of this Contract to provide any other financial reports/information not listed above as deemed necessary by DHCS to properly monitor the Contractor and/or subcontractor's financial condition. ~~The Contractor shall provide all requested material to DHCS within 45 calendar days.~~

Exhibit A, Attachment 3
Management Information System

1. Management Information System (MIS) Capability

A. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's ~~e~~**E**ncounter ~~d~~**D**ata submission. All data related to this **C**~~c~~ontract shall be available to DHCS and to the Centers to Medicare and Medicaid Services **(CMS)** upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

1. All Medi-Cal eligibility data**;**
2. Information of Members enrolled in Contractor's plan**;**
3. Provider claims status and payment data**;**
4. Health care services delivery **E**~~e~~ncounter **D**~~d~~ata**;**
5. Provider network information**;** and
6. Financial information as specified in Exhibit A, Attachment 1, Provision 8~~, Administrative Duties/Responsibilities~~.

B. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility, Provider, Encounter Claims, Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient**,** and successful.

2. Encounter Data Submittal

A. Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of ~~e~~**E**ncounter ~~d~~**D**ata **to DHCS, as defined in state and federal law and applicable DHCS APLs,** for all **items and** services for which Contractor has incurred any financial liability **furnished to a Member under this contract**, whether directly or through subcontracts or other arrangements**, including capitated providers**. Encounter ~~d~~**D**ata shall **be submitted on at least a monthly basis in a form and manner specified by DHCS** ~~include data elements specified in DHCS' most recent Encounter Data Element Dictionary for Managed Care Plans and all existing MMCD Policy Letters related to encounter data reporting~~.

Exhibit A, Attachment 3
Management Information System

B. Contractor shall require subcontractors and non-contracting providers to provide ~~e~~**E**ncounter ~~d~~**D**ata to Contractor, which allows the Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall also have in place mechanisms, including edits and reporting systems sufficient to ~~assure~~ **ensure** ~~e~~**E**ncounter ~~d~~**D**ata is complete and accurate prior to submission to DHCS.

C. Contractor shall submit **complete, timely, reasonable, and accurate** **E**~~e~~ncounter **D**~~d~~ata **on at least a monthly basis. DHCS will also allow Contractor to submit on a more frequent basis if preferable.** ~~to DHCS upon the request of DHCS. The implementation of regular encounter data reporting timeframes will be aligned with the DHCS implementation of a standardized encounter data reporting format. DHCS maintains its right to change the frequency, and if DHCS were to revise the timeframe then DHCS shall provide at least 30 calendar day notice of the change to the Contractor. DHCS may hold the Contractor accountable to requirements specified in the most recent Encounter Data Element Dictionary for Managed Care Plans and all existing Policy Letters related to encounter data reporting.~~

D. DHCS will measure the quality of the Encounter Data for completeness, timeliness, reasonability, and accuracy.

~~D~~**E**. **If DHCS finds deficiencies regarding Encounter Data or the quality of Encounter Data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data.** ~~Upon written notice by DHCS that the encounter data is insufficient or inaccurate,~~ Contractor shall ensure that corrected data is resubmitted within 15 calendar days of ~~receipt~~ **the date** of DHCS' notice. Upon Contractor's written request, DHCS may provide a written extension for submission of corrected ~~e~~**E**ncounter ~~d~~**D**ata.

3. MIS/Data Correspondence

Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to DHCS a ~~Corrective Action Plan~~ **CAP** with measurable benchmarks within 30 calendar days from the date of the postmark of DHCS' written notice to Contractor. Within 30 calendar days of DHCS' receipt of **CAP**, DHCS shall approve the ~~Corrective Action Plan~~ **CAP** or request revisions. Within 15 calendar days after receipt of a request for revisions to the ~~Corrective Action Plan~~ **CAP,** Contractor shall submit a revised ~~corrective Action Plan~~ **CAP** for DHCS**'** approval. **DHCS may continue to request revisions to**

the CAP until it is finally approved by DHCS, or until DHCS determines that Contractor is not acting in good faith to comply with the contract requirement to submit data. If contractor is not complying with the timelines identified in its approved CAP, contractor is not acting in good faith. If DHCS determines that Contractor is not acting in good faith to comply with the requirement to submit data, then DHCS may issue sanctions and/or terminate the contract as provided in Welfare & Institutions Code Section 14304.

4. Health Insurance Portability and Accountability Act (HIPAA)

Contractor shall comply with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements, and all related **f**~~F~~ederal and **s**~~S~~tate regulations ~~promulgated from this Act~~, as they become effective.

Exhibit A, Attachment 4
Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) **in accordance with 42 CFR 460.32(a)(9), 460.130, 460.132, 460.134, 460.136, 460.138, and 460.140, and the standards in 28 CCR Section 1300.70.** Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services, on its behalf, in any setting. Contractor shall be accountable for the quality of all **c**overed **s**ervices regardless of the number of Contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of Contractor's organization, the designation of a Quality Improvement Committee **(QIC)** with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of employed or contracted Physicians and contracting providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body**, in compliance with 42 CFR 460.62, and** including, at a minimum, the following:

A. ~~A~~**a**pproves the overall QIS and the annual report of the QIS**;** ~~.~~

B. ~~A~~**a**ppoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS**;** ~~.~~

C. ~~R~~**r**outinely receives written progress reports from the QIS committee describing actions taken, progress in meeting QIS objectives, and improvements made**; and** ~~.~~

~~D. Formally reviews (at least annually) a written report on the QIS which includes; studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered; and assess the QIS' continuity, effectiveness, and current acceptability.~~

Exhibit A, Attachment 4
Quality Improvement System

~~E~~**D**. Directs the operational QIS to be modified on an ongoing basis and tracks all review findings for follow-up.

4. Quality Improvement Committee

A. Contractor shall implement and maintain a ~~Quality Improvement Committee (~~QIC~~)~~ designated by and accountable to the governing body**.**~~;~~ **The QIC** ~~the committee~~ shall be facilitated by the Medical Director or a Physician designee. Contractor must ensure that ~~s~~**S**ubcontractors, who are representative of the composition of the contracted provider network, including but not limited to ~~s~~**S**ubcontractors who provide health care services to ~~Seniors and Persons with Disabilities~~ **SPDs and persons with** ~~or~~ chronic conditions (such as asthma, diabetes, **and** congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC. ~~The role, structure, and function of this committee shall be delineated.~~

B. The committee shall meet at least quarterly, but as frequently as necessary, to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body, in writing, on a scheduled basis.

C. Contractor shall ensure that a summary of quality assurance activities are submitted to DHCS quarterly ~~for review~~. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of the Members.

D. Contractor shall ensure that the Medical Director shall be directly involved in the implementation of Quality Improvement activities.

5. Provider Participation

A. Contractor shall ensure that **contracting** ~~P~~**p**hysicians and other ~~health care~~ providers **from the community** shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep **contracting** providers informed of the written QIS, its activities and outcomes.

B. Contractor shall maintain employment agreements and provider Contracts, which include a requirement securing cooperation with the QIS. Contractor shall ensure that contracted hospitals and other subcontractors shall allow Contractor access to the Medical Records of its Members.

Exhibit A, Attachment 4
Quality Improvement System

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for ~~Quality Improvement~~ **QI** functions and responsibilities even when it delegates ~~Quality Improvement~~ QI activities to its subcontractors. Contractor shall maintain a system to ensure accountability of delegated ~~Quality Improvement~~ **QI** activities including:

1) Maintenance of policies and procedures which describe**:** **(i)** delegated activities, **(ii)** ~~Quality Improvement~~ **QI** authority, function, and responsibility, **(iii)** how each **S**~~s~~ubcontractor shall be informed of its scope of ~~Quality Improvement~~ **QI** responsibilities, and **(iv)** ~~the~~ Subcontractor's accountability for delegated activities**;**~~.~~

2) Establish reporting standards to include findings and actions taken by the ~~s~~**S**ubcontractor as a result of the ~~Quality Improvement~~ **QI** activities with the reporting frequency to be at least quarterly~~.~~**;**

3) Maintenance of written procedures and documentation of continuous monitoring ~~and evaluation~~ of the delegated functions, evidence**ing** that the ~~actual~~ **q**~~Q~~uality of **c**~~C~~are being provided meets professionally**-**recognized standards**;**~~.~~

4) Assurance and documentation that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities~~.~~**;**

5) Contractor shall approve the delegate's QIS, including its policies and procedures, which shall meet standards set forth by Contractor**; and**~~.~~

6) Contractor shall ensure that the ~~actual~~ ~~Q~~**q**uality of ~~C~~**c**are being provided is ~~being~~ continuously monitored and evaluated.

B. Contractor shall implement and maintain ~~Quality Improvement~~ **QI** channels and facilitate coordination with other performance monitoring activities, including risk management and resolution and monitoring of Member **g**~~G~~rievances. Contractor's QIS shall maintain linkages with other management functions such as network changes, medical management systems (i.e. pre-certification), practice feedback to **p**~~P~~hysicians, patient education/health education, Member services, human resources feedback, and cultural and linguistic services feedback.

Exhibit A, Attachment 4
Quality Improvement System

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. The organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

B. The organizational chart ~~showing the~~ **evidencing** key staff and the committees and bodies responsible for ~~Quality Improvement~~ **QI** activities including reporting relationships of QIS committee(s) and staff within Contractor's organization.

C. The qualifications of staff responsible for ~~Quality Improvement~~ **QI** studies and activities, including education, experience**,** and training.

D. A description of the system for provider review of QIS findings, which**,** at a minimum, demonstrates Physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers~~,~~ regarding QIS study outcomes.

E. The role, structure, and function of the ~~Quality Improvement committee~~ **QIC**.

F. The processes and procedures designed to ensure that all **M**~~m~~edically **N**~~n~~ecessary **C**~~c~~overed **S**~~s~~ervices are available and accessible to all Members regardless of **sex,** race, color, national origin, creed, ancestry, **ethnic group identification,** religion, ~~language,~~ age, gender, marital status, sexual orientation, health status**, medical condition, mental disability,** ~~or~~ **physical** disability, **or genetic information** and that all Covered Services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standard.

H. A description of the quality of clinical care services provided, including, but not limited to, preventive services for adults, ~~P~~**p**rimary ~~C~~**c**are, specialty, emergency, inpatient, and ancillary care services.

I. A description of the activities, including activities used by Members that are ~~Seniors and Persons with Disabilities~~ **SPDs** or persons with chronic conditions, designed to assure the provision of **C**~~c~~ase **M**~~m~~anagement, coordination**,** and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services**,** and care management.

8. Quality Improvement Annual Report

Contractor shall develop an annual Quality Improvement **R**~~r~~eport **(QIR)** for submission to DHCS ~~by the end of each contractor's fiscal year~~ **on an annual basis**. The annual report shall include:

A. A comprehensive assessment of the ~~Quality Improvement~~ **QI** activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the ~~Quality Improvement~~ **QI** program~~,~~ including, but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; and, outcomes/findings from Quality Improvement ~~Systems~~ **Projects** (QI~~S~~**P**s), consumer satisfaction surveys**,** and collaborative initiatives.

B. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. **Including** the ~~Include the corrective action plan~~ **CAP, if any,** developed to address noted deficiencies.

C. An assessment of ~~s~~**S**ubcontractor's performance of delegated ~~Quality Improvement~~ **QI** activities.

9. Systematic Process of Quality Improvement

A. Contractor's QIS shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered on an ongoing basis. Contractor shall implement a QIS that addresses the quality of clinical care as well as the quality of health services delivery. Contractor shall ensure that the studies described below reflect the population served in terms of age groups, disease categories**,** and special

risk status. The QIS shall continuously monitor care against practice guidelines or clinical standards and shall use appropriate **q**~~Q~~uality ~~I~~**i**ndicators as measurable variables. Contractor shall ensure that **the** data collected shall be analyzed by the appropriate health professionals, and system issues shall be addressed by the Interdisciplinary Team (IDT). Contractor shall undertake corrective actions within the time frames determined by DHCS whenever problems are identified. Contractor shall maintain a system for tracking the issues over time to ensure that actions for improvement are effective.

B. Contractor shall perform **q**~~Q~~uality of **c**~~C~~are **s**~~S~~tudies on an ongoing basis as listed below:

1) Clinical Areas

a. Immunizations and health screens~~.~~

b. Adult preventive services~~.~~

2) Health Services Delivery Areas

a. Utilization of services~~.~~

b. Coordination of care~~.~~

c. Continuity of care~~.~~

d. Health education~~.~~

e. Emergency **s**~~S~~ervices~~.~~

f. Member satisfaction surveys~~.~~

g. Access to care~~.~~

C. Contractor shall use the following standards and guidelines for **a**~~A~~dult **p**~~P~~reventive **c**~~C~~are based on guidelines contained in the Report of the United States Preventive Services Task Force. For ~~Q~~**q**uality of ~~C~~**c**are studies in the health services delivery areas, Contractor shall use the specific standards set forth in the pertinent subsections. Contractor's Quality of Care studies may include health services delivery issues other than the priority areas identified. For other clinical or health services delivery areas where DHCS has not specified clinical standards or

practice guidelines, Contractor shall submit these standards or guidelines to DHCS for approval six weeks prior to conducting the studies.

D. To the extent feasible and appropriate, Contractor shall use the most recent Health Plan Employer Data and Information Set (HEDIS) indicators for the required **g**~~Q~~uality of **c**~~C~~are studies indicated in paragraph B~~, Quality of Care Studies~~.

10. Facility Review

A. Contractor shall conduct **f**~~F~~acility reviews on all **s**~~S~~ervice **s**~~S~~ites as part of the **c**~~C~~redentialing and recredentialing procedures. Facility reviews for **m**~~M~~edical **s**~~S~~pecialty **p**~~P~~rovider sites shall **also** be performed as follows:

1) Upon receipt by Contractor of any complaint received from a Member regarding a **m**~~M~~edical **s**~~S~~pecialty **p**~~P~~rovider**, after other means of communication (phone, email, etc.) have been unsuccessful for 10 business days**;

2) At the site of the **m**~~M~~edical **s**~~S~~pecialty **p**~~P~~rovider set forth in the Member complaint; and

3) Within 15 **business** days of receipt by Contractor of the complaint.

B. Facilities used by Contractor for providing **c**~~C~~overed **s**~~S~~ervices shall comply with all applicable federal and **s**~~S~~tate laws and regulations including, but not limited to, the provisions of Title 22, CCR, Section 53230.

C. Contractor shall ensure that its **f**~~F~~acility review procedures shall be submitted to DHCS for approval prior to use and shall comply with the current and/or revised requirements. These currently include the following categories:

1) Service and Provider Sites

a. Front office procedures including:

(1) Telephone access, triage, and advice~~.~~

(2) Appointment scheduling, as well as a system for coordinating interpreters for Limited English Proficient (LEP) Members~~.~~

(3) Missed appointment and follow-up~~.~~

(4) Referral appointment and follow-up~~.~~

(5) Referral (consultation) reports, lab and **x**~~X~~-ray follow-up~~.~~

b. Fire and disaster plan.

c. Infection control.

d. Handling of bio-hazardous wastes.

e. Health education.

f. Medical emergencies.

g. Pharmacy policies (including handling of sample drugs).

h. Medical Records storage and filing.

i. Medical Records documentation.

j. Grievances.

k. Laboratory services.

l. Radiological services.

m. Preventive services for adults.

n. Facility access for physically disabled individuals.

o. Informed consent procedures.

p. Linguistic services access.

2) Dental Provider Sites

Contractor shall develop, implement, and maintain a tool for monitoring dental providers and submit to DHCS for review and

approval. ~~Contractor may develop its own tool or use the tool provided by DHCS.~~

D. Contractor shall ensure that **f**~~F~~acility reviews are completed prior to new ~~Pace~~ **PACE** Centers expansion. Contractor shall submit the results of ~~Pace~~ **PACE** Centers expansion reviews to DHCS at least two weeks following the Licensing & Certification surveys and **f**~~F~~ire ~~Marshall~~ **marshal** clearance prior to plan or **s**~~S~~ervice **s**~~S~~ite operation. For ~~Pace~~ **PACE** Centers expansion reviews, Contractor shall submit an aggregate report of the review results.

E. Contractor shall provide any necessary assistance to DHCS in its conduct**ing** of **F**~~f~~acility inspections and medical reviews of the **q**~~Q~~uality of **c**~~C~~are being provided to Members. Contractor shall ensure correction of deficiencies as identified by those inspections and reviews according to the timeframes delineated by DHCS in the resulting reports.

F. Contractor shall ensure that sites with major, uncorrected deficiencies are not allowed to begin operation. Contractor shall take corrective action if a DHCS inspector finds a site to be in substantial non-compliance. Contractor shall require such site to cease providing services to Members~~;~~**,** provided that such site may not be required to cease providing services in the event DHCS and Contractor agree to a plan of corrective action to be implemented by the site, and such plan is being implemented to the satisfaction of DHCS.

G. Contractor shall remain responsible for the oversight and monitoring of delegated **f**~~F~~acility review activities.

11. Credentialing and Recredentialing

Contractor shall develop and maintain written policies and procedures that include initial **c**~~C~~redentialing, recredentialing, recertification, and reappointment of **p**~~P~~hysicians including Primary Care Physicians (PCP**s**) and specialists in accordance with ~~the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03~~ **DHCS All Plan Letter (APL) 19-004**. Contractor shall ensure ~~those~~ **the** policies and procedures are reviewed and approved by the governing body or designee. Contractor shall ensure the responsibility for recommendations regarding **c**~~C~~redentialing decisions will rest with a **c**~~C~~redentialing committee or other peer review body.

Exhibit A, Attachment 4
Quality Improvement System

A. Standards

All providers of **c**~~C~~overed **s**~~S~~ervices must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified**,** or registered. All providers must ~~have~~ **be in** good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Delegated Credentialing

Contractor may delegate **c**~~C~~redentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with provision 6. ~~Delegation of Quality Improvement Activities, above.~~

C. Credentialing Provider Organization Certification

Contractor and their subcontractors (e.g. a medical group or independent ~~physician~~ **Physician** organization) may obtain **c**~~C~~redentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). Contractor may accept evidence of **current** NCQA POC certification in lieu of a monitoring visit at delegated ~~Physician~~ **physician** organizations.

D. Disciplinary Actions

Contractor shall implement and maintain a system for ~~the~~ reporting ~~of~~ serious quality deficiencies that result in suspension or termination of a practitioner**,** to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including~~,~~ reducing, suspending**,** or terminating a practitioner's privileges. Contractor shall implement and maintain a **process for providers to appeal** ~~provider appeal process~~ **such disciplinary actions**.

E. Medi-Cal and Medicare Provider Status

Contractor will verify that their **S**~~s~~ubcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on

the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list~~;~~ cannot participate in Contractor's provider network.

Contractor to follow the requirements set forth in APL 16-001 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf

F. Health Plan Accreditation

If Contractor has received a rating of "Excellent**,**"~~,~~ "Commendable**,**" or "Accredited" from NCQA, Contractor shall be ~~"~~deemed~~"~~ to meet the DHCS requirements for **c**~~C~~redentialing and will be exempt from the DHCS medical review audit of **c**~~C~~redentialing.

Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

G. Credentialing of Other Non-Physician Medical Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of **n**~~N~~urse **p**~~P~~ractitioners, **c**~~C~~linical **n**~~N~~urse **s**~~S~~pecialists and **p**~~P~~hysician **~~A~~assistants** have been verified in accordance with **s**~~S~~tate requirements **applicable to the provider category**.

12. ~~Member~~ Medical Records

A. General Requirement

~~Contractor shall maintain for each Member who has received medical services during enrollment, a legible Medical Record kept in detail consistent with good medical and professional practice which permits effective internal professional review and external medical audit processes and which facilitates an adequate system for follow-up treatment. Medical records shall be located at the Pace Centers the Member receives services and maintained in accordance with Title 22, CCR, Section 53284. Contractor shall ensure that appropriate Medical Records for the Member shall be available to all staff and health care providers at each Encounter.~~

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42

CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861, and Medi-Cal Managed Care Policy Letter 14-004.

B. Medical Records

Contractor shall develop, implement, and maintain written procedures pertaining to any form of **m**~~M~~edical **r**~~R~~ecords:

1) For storage and filing of **m**~~M~~edical **r**~~R~~ecords**,** including: collection, processing, maintenance, storage, retrieval identification, retention, and distribution**;** ~~.~~

2) To ensure **m**~~M~~edical **r**~~R~~ecords are protected and confidential in accordance with all federal and **s**~~S~~tate laws**;** ~~.~~.

3) For release of information and obtaining consent for treatment**;** ~~.~~ **and**

4) ~~To ensure maintenance of Medical Records in accordance with accepted professional standards. All entries must be legible, clear, complete, and appropriately authenticated and dated.~~ **To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copies).**

C. On-Site Medical Record

Contractor shall ensure that an individual ~~shall be~~ **is** delegated the responsibility of securing and maintaining **m**~~M~~edical **r**~~R~~ecords at each ~~Service~~ ~~S~~**s**ite.

D. Member Medical Record

Contractor shall ensure that a complete **m**~~M~~edical **r**~~R~~ecord is maintained for each Member in accordance with Title 22 **,** ~~,~~CCR~~,~~ Section 53284, ~~located at the Pace Centers where the Member receives services~~ that reflects all aspects of patient care, including ancillary services**, and at a minimum includes:** ~~. Each Medical Record shall at a minimum include all requirements for Member Medical Records, as outlined in the federal PACE regulations 42 CFR, Section 460.210 (a)-(d), as well as the following provisions:~~

Exhibit A, Attachment 4
Quality Improvement System

1) Member identification on each page**, with**~~,~~ personal **and/or** biographical data in the record.

2) The identity of the Member's PCP.

3) All entries dated and author identified**,** ~~by first initial, last name and title.~~ For Member visits, the entries shall include, at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4) The record shall contain a problem list, a current medications list, a complete record of immunizations**,** and health maintenance or preventive services rendered.

5) Allergies and adverse reactions are prominently noted in the record.

6) All informed consent documentation, including the human sterilization consent procedures required by Title 22~~,~~ CCR~~,~~ Sections 51305.1 through 51305.6, if applicable.

7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions ~~while the patient is enrolled~~.

8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9) Documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

10) Member's preferred language (if other than English) **or use of auxiliary aids and services for effective communication (Members with disabilities),** prominently noted in the record as well as the request or refusal of language **and/or** interpretation services**; and**~~.~~

11) Health education behavioral assessment and referrals to health education services.

Exhibit A, Attachment 4
Quality Improvement System

E. Contractor shall implement and maintain a system to review records for compliance with Medical Records standards, and institute a Corrective Action Plan when necessary. Contractor shall ensure that Medical Records shall be reviewed for:

1) ~~U~~**u**niformity of forms~~.~~**;**

2) ~~L~~**l**egibility (the record is legible to a person other than the writer)~~.~~**;**

3) ~~C~~**c**ompleteness~~.~~**;**

4) ~~Q~~**q**uality and appropriateness of services provided~~.~~**;**

5) ~~I~~**i**mmunizations~~.~~**;**

6) ~~P~~**p**reventive health screening~~.~~**; and**

7) ~~A~~**a**uthentication.

13. Laboratory Certification

A. To ensure that each laboratory used to perform services under this Contract or by subcontract complies with federal and State law, each location at which any test or examination on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, treatment or assessment of any disease, impairment or health of a human being is performed shall have in effect:

1) A current, unrevoked or unsuspended certificate, certificate for provider-performed microscopy procedures, certificate of accreditation, certificate of registration or certificate of waiver issued under the requirements of 42 United States Code, Section 263a and the regulations adopted thereunder and found at 42 CFR, Part 493; and, either

a. A current, unrevoked or unsuspended license or registration issued under the requirements of Chapter 3 (commencing with Section 1200) of Division 2 of the California Business and Professions Code and the regulations adopted thereunder; or,

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b. Be operated in conformity with Chapter 7 (commencing with Section 1000) of Division 1 of the California Health and Safety Code and the regulations adopted thereunder.

B. All places used to perform tests or examinations on human biological specimens (materials derived from the human body) are, by definition, "laboratories" under federal and ~~S~~**s**tate law.

C. Laboratories may exist, therefore, at ~~N~~**n**urses' stations within hospitals, clinics, ~~S~~**s**killed ~~N~~**n**ursing ~~F~~**f**acilities, operating rooms, surgical centers, ~~r~~**R**ural ~~h~~**H**ealth ~~c~~**C**linics **(RHCS)**, Physician offices, Planned Parenthood clinics, mobile labs, health fairs, and city, county or State labs.

D. Any laboratory that does not comply with ~~the~~ appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare, Medicaid**,** or Medi-Cal programs.

E. Member Dental Records

Contractor shall maintain a complete dental record and implement a system to review dental records, which at a minimum shall include:

1) Legible, organized, appropriately signed records.

a. Complete records with detailed findings;

b. Signed general and informed consent forms ;and

c. Complete treatment plan.

2) A medical history, current medications, allergies, and medical clearance if necessary.

Exhibit A, Attachment 5
Utilization Management

1. Utilization Management (UM) Program

Contractor shall develop, implement, and ~~maintain~~ **continually update and improve** a ~~Utilization Management (~~UM~~)~~ program which ~~includes a list of services that require Prior Authorization, persons responsible for UM and their qualifications, procedures to evaluate Medical Necessity, criteria used for approval, referral, and Denial of services, information sources, and the process used to review and approve the provision of Medically Necessary Covered Services.~~ **ensures appropriate processes are used to review and approve the provision of medically necessary covered services. Contractor is responsible to ensure that the UM program includes:**

A. Qualified staff who are responsible for the UM program.

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management. Compensation of staff or Subcontractors that conduct UM activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

C. Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of the specific criteria used by the Contractor.

E. Contractor shall communicate to health care practitioners the procedures and services that require Prior Authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain Prior Authorization for these services.

F. An established specialty referral system to track and monitor referrals requiring Prior Authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness for the referrals. This specialty referral system should include non-contracting providers.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures; and.

G. The integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

These activities shall be done in accordance with Health and Safety Code section 1363.5 and California Code of Regulations, title 28, section 1300.70, subdivisions (b)(2)(H) & (c).

2. ~~Pre~~Prior-Authorization and Review Procedures

Contractor shall ensure that its ~~pre~~**prior**-authorization**,** ~~and~~ concurrent review**, and retrospective review** procedures ~~shall~~ meet the following minimum requirements:

A. **Consult with the requesting Provider for medical services, when appropriate.**

Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition or disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

~~A~~**B**. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, **in** whole or in part, on the basis of **M**~~m~~medical **N**~~n~~ecessity. For purposes of this provision, a qualified ~~P~~**p**hysician or Contractor's ~~P~~**p**harmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of**,** and pursuant to**,** criteria established by ~~the Plan~~ **Contractor's** ~~M~~**m**edical ~~D~~**d**irector~~, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent~~.

Exhibit A, Attachment 5
Utilization Management

~~B~~**C**. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is ~~updated regularly and~~ consistently applied**, regularly reviewed, and updated**.

~~C~~**D**. **The r**~~R~~easons for decisions are clearly documented.

~~D~~**E**. ~~There is a well-publicized Appeals procedure for both providers and Members.~~
Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13. There shall be a well-publicized appeals procedure for both providers and patients.

~~E~~**F**. Decisions and appeals are made in a timely manner **and are not unduly delayed for medical conditions requiring time-sensitive services**.

G. Prior Authorization requirements shall not be applied to emergency services, preventive services, sexually transmitted disease services, and HIV testing.

H. Records, including any notice of action (NOA), shall meet the retention requirements described in Exhibit E, Attachment 2, provision 19, Audit.

I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be provided orally or in writing. Notice to the member shall be in writing and in accordance with the requirements in Exhibit A, Attachment 13, Member Services, Provision 6, Denial, Deferral, or Modification of Prior Authorization Requests.

~~Contractor shall ensure that Prior Authorization requirements are not applied to Emergency Services, preventive services, and Sensitive Services.~~

3. Timeframes and Medical Authorization

A. Emergency Care & Post-Stabilization: contractor must comply with the timeframes and authorization procedures set forth in 42 CFR 460.100, which are set forth in Exhibit A, Attachment 8, Provision 11.

Exhibit A, Attachment 5
Utilization Management

B. Non-urgent care following an exam in the emergency room: response to request within one hour or it will be deemed approved.

C. Concurrent review of authorization for treatment regimen already in place: within five working days or less, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code section 1367.01(h)(3), or any future amendments thereto.

D. Retrospective review: within 30 calendar days in accordance with Health and Safety Code section 1367.01(h)(1), or any future amendments thereto.

E. Pharmaceuticals: for all covered outpatient drug Prior Authorization requests, provide notice by telephone, fax, email or other electronic communication within 24 hours of receipt of the request, and in emergency situations dispense at least a 72-hour supply of the covered outpatient drug in accordance with Welfare and Institutions Code section 14185, 42 CFR 438.3(s)(6), and Section 1927(d)(5)(A) of the Social Security Act or any future respective amendments thereto.

F. Routine Authorizations: within five working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from Prior Authorization) in accordance with Health and Safety Code, section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

G. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than 72 hours after receipt of the request for services. The Contractor may extend the three working days time

period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies to satisfaction of DHCS the need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

H. Hospice Inpatient Care: 24-hour response.

~~3~~4. Review of Utilization Data

Contractor shall ~~ensure that~~ **include within** the UM program ~~has~~ mechanisms to detect both under and over-utilization of **health care** services. **Contractor's internal reporting mechanisms used to detect member utilization patterns shall be reported to DHCS upon request.**

~~4~~5. Delegating UM Activities

Contractor ~~shall ensure that~~ **may** delegate~~d~~ UM activities**.** ~~to Subcontractors are approved and regularly evaluated. Contractor shall ensure that this process is documented~~. **If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6**.

Exhibit A, Attachment 6
Provider Network

1. Network Composition

Contractor shall demonstrate the continuous availability and accessibility of adequate numbers of institutional **f**~~F~~acilities, **s**~~S~~ervice **l**~~L~~ocations, **s**~~S~~ervice ~~S~~**s**ites, and professional, allied, and supportive paramedical personnel and providers to provide **c**~~C~~overed **s**~~S~~ervices including the provision of all medical care necessary under emergency circumstances on a 24 hour, seven day**s**-**per** ~~a~~-week basis.

Contractor shall ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and PACE Centers within each service area.

2. Provider to Member Ratios

Contractor shall ensure ~~the~~ **that** network**s continuously** ~~is sufficient to~~ satisfy the following full-time equivalent provider to Member ratios:
One full-time equivalent ~~Primary Care Physician (~~PCP~~)~~ per 350 Members.

3. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with Title 22**,** CCR**,** Sections 51240 and 51241, and that full time equivalent **p**~~P~~hysician **s**~~S~~upervisor to **n**~~N~~on-**p**~~P~~hysician **m**~~M~~edical **p**~~P~~ractitioner ratios at PACE ~~Service Sites~~**Centers** do not exceed the following:

A. ~~N~~**n**urse practitioners 1:4

B. ~~P~~**p**hysician assistants 1:2

C. ~~F~~**f**our ~~(4)~~ ~~N~~**n**on-~~P~~**p**hysician ~~M~~**m**edical ~~P~~**p**ractitioners in any combination that does not include more than two ~~(2)~~ physician assistants.

4. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24 hours a day, seven days-per-week basis. This designated emergency service facility will have one or more Physicians and one or more nurses on duty in the facility at all times.

Exhibit A, Attachment 6
Provider Network

~~4~~5. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care **in accordance with Welfare and Institutions Code section 14182(c), criteria (2)**. Contractor shall provide a recording/tracking mechanism for each authorized, **d**~~D~~enied**,** or modified referral. In addition, Contractor shall offer second opinions by ~~S~~**s**pecialists to any Member upon request.

6. Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access to FQHC services, including those in 42 United States Code section 1396b(m). Contractor shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provision 7.

~~5~~7. Physician Services

~~Contractor shall provide Physician services:~~
Contractor shall provide physician services ~~D~~**d**irectly through ~~P~~**p**hysicians who are employees of Contractor or who have agreements with Contractor to provide health care services or **who** are providers of ~~U~~**u**nusual or ~~S~~**s**eldom-~~U~~**u**sed ~~H~~**h**ealth ~~C~~**c**are ~~S~~**s**ervices as defined by DHCS.

~~6~~8. Continuity of Care

Contractor shall establish and operate a system to assure continuity of care through appropriate referral of Members needing specialty health care services, documentation of referral services in Member ~~M~~**m**edical ~~R~~**r**ecords, monitoring of Members with ongoing medical conditions, documentation of Member emergency medical encounters in ~~M~~**m**edical ~~R~~**r**ecords, with appropriate follow-up as medically indicated, and coordinated hospital discharge planning that includes necessary post-discharge care.

~~7~~9. Emergency Management Plan

Contractor shall maintain an emergency management plan~~,~~ **in compliance with 42 CFR 460.84, including a** response and recovery approach that provides ~~a process~~ for **the** ~~mitigating~~ **mitigation**, ~~responding~~ **response** to, and ~~recovering~~ **recovery** from an emergency.

Exhibit A, Attachment 6
Provider Network

~~8~~10. Plan Physician Availability

Contractor shall have a plan or contracting ~~P~~**ph**ysician available 24 hours per day, seven days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically Necessary post-stabilization services, and for general communication with emergency room personnel.

~~9~~11. Plan Subcontractors

Contractor shall submit to DHCS~~, in accordance with PACE Policy Letter 03-01~~, a quarterly updated subcontractor listing, which, at a minimum, contains the following information:

A. Headers to indicate city or region names (in alphabetical order)**;**

B. Specialty (e.g. Optometry)**;**

C. Provider's name (last, first-listed alphabetically)**;**

D. Street address**;**

E. City including zip codes**;**

F. Telephone number including area code**;**

G. Languages (other than English) spoken at the provider site**; and**

H. Medical Group/Institutional/Specialty name (e.g. University of California)**.**

Contractor shall notify DHCS in the event the agreement with the Subcontractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

~~10~~12. Ethnic and Cultural Composition

Contractor shall ~~make all due diligence to~~ ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

~~11~~13. Subcontract**s** ~~Requirements~~

Exhibit A, Attachment 6
Provider Network

Contractor may ~~elect to~~ enter into **s**~~S~~ubcontracts with other entities in order to fulfill the obligations of the Contract. ~~In doing so, Contractor shall meet the subcontracting requirements as stated in Title 22, CCR, Section 53250 and this Contract~~. **Contractor shall evaluate the prospective Subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 460.70(a), (b), (c), and (d).**

A. Subcontract **Requirements**

Each **s**~~S~~ubcontract **as defined in Exhibit E, Attachment 1,** shall contain:

1) Specification of the services to be provided by the ~~s~~**S**ubcontractor~~.~~**:**

2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract~~.~~**:**

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in paragraph ~~B~~**C** Departmental ~~Approval, of this provision.~~**:**

4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation, and termination~~.~~**:**

5) Language comparable to Exhibit A, Attachment 8, provision 7 for those Subcontractors at risk for non-contracting emergency services;

~~5~~**6**) Subcontractor's agreement to submit reports as required by Contractor~~.~~**:**

7) Specification that the Subcontractor shall comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

~~6~~**8**) Subcontractor's agreement to make all of its **premises, facilities, equipment**, books**,** ~~and~~ records**, contracts, computer and other electronic systems** pertaining to the goods and services furnished under the terms of the subcontract, available for **the purpose of an audit, evaluation,** inspection, examination**,** or copying**, including**

but not limited to access requirements and state's right to monitor, as set forth in Exhibit E, Attachment 2, provision 20:

a. By DHCS, **CMS,** Department of Health and Human Services (DHHS), and Department of Justice (DOJ)**, DMHC or their designees**.

b. At all reasonable times at the **S**~~s~~ubcontractor's place of business or at such other mutually agreeable location in California.

c. In a form maintained in accordance with the general standards applicable to such book or record keeping.

d. For a term of at least ~~six (6)~~ **ten** years from the close of ~~DHCS'~~ **the current** fiscal year in which the ~~Subcontract was in effect~~ **service occurred; in which the record or data was created or applied; and for which the financial record was created**.

e. Including all ~~E~~**e**ncounter data for a period of at least ~~six(6)~~ **ten** year**s**.

f. If DHCS, CMS, or the Department of Health and Human Services (DHHS) Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time, and

g. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor.

~~7~~**9**) Full disclosure of the method and amount of compensation or other consideration to be received by the S~~s~~ubcontractor from Contractor.

~~8~~**10**) Subcontractor's agreement to maintain and **to** make available to DHCS, upon request, copies of all **S**~~s~~ub-**S**~~s~~ubcontracts and to ensure that all **S**~~s~~ub-**S**~~s~~ubcontracts are in writing and require that the ~~Sub-~~Subcontractor:

a. Make all **premises, facilities, equipment,** applicable books and records, **contracts, computer, or other electronic systems related to this Contract**, available at all reasonable times for **audit,** inspection, examination or copying by DHCS, DHHS,**CMS,** ~~and~~ DOJ**, or their designees.**

b. ~~Retain such books and records for a term of at least six (6) years from the close of DHCS' fiscal year in which the sub-contract is in effect.~~
Retain all records and documents for a minimum of ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

~~9~~**11**) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, provision 15~~.~~ B~~.~~ ~~Phase-out Requirements~~, **subparagraph B** in the event of Contract termination.

12) Subcontractor's agreement to assist Contractor and DHCS in the transfer of care in the event of Sub-contract termination for any reason.

~~10~~**13**) Subcontractor's agreement that assignment or delegation of the ~~S~~**s**ubcontract shall be void unless prior written approval is obtained from DHCS.

~~11~~**14**) Subcontractor's agreement to hold harmless both the ~~S~~**s**tate and Members in the event Contractor cannot or ~~shall~~ **will** not pay for services performed by the ~~s~~**S**ubcontractor pursuant to the ~~S~~**s**ubcontract.

~~12~~**15**) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the ~~s~~**S**ubcontractor's possession, in accordance with Exhibit E, Attachment 2, provision 25. ~~Records Related to Recovery for Litigation~~.

~~13~~**16**) subcontractor's agreement to provide interpreter services for Members at all ~~Service Sites and Service Locations~~ **provider sites.**

Exhibit A, Attachment 6
Provider Network

~~14~~**17**) Subcontractor's right to submit a~~n Appeal~~ **grievance** and Contractor's formal process to resolve **p**~~P~~rovider ~~Appeals~~ **grievances**.

~~15~~**18**) Subcontractor's agreement to participate and cooperate in Contractor's ~~Quality Improvement System~~ **QIS**.

~~16~~**19**) If Contractor delegates ~~Quality Improvement~~ **QI** activities, **s**~~S~~ubcontract shall include those provisions stipulated in Exhibit A, Attachment 4, provision 6~~. Delegation of Quality Improvement Activities~~**; and**

~~17~~**20**) Subcontractor's agreement to comply with all applicable requirements of ~~the~~ DHCS, Medi-Cal Managed Care Program**,** and the ~~Long-Term Care Division (LTCD)~~ **Integrated Systems of Care Division (ISCD)**.

B. Department Approval

1) **Except as provided in Exhibit A, Attachment 8, provision 7, regarding FQHCs and RHCS, a** provider ~~S~~**s**ubcontract entered into by a Contractor **which is not a federally qualified HMO** shall become effective upon approval by DHCS in writing or by operation of law where DHCS has acknowledged receipt of the proposed ~~S~~**s**ubcontract, and has failed to approve or disapprove the proposed ~~S~~**s**ubcontract within sixty (60) days of receipt. Within five (5) State working days of receipt, DHCS shall acknowledge verbally or in writing the receipt of any material sent to DHCS by Contractor for approval.

2) Subcontract amendments shall be submitted to DHCS for prior approval at least ~~thirty (~~30~~)~~ **calendar** days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved or disapproved by DHCS, shall become effective by operation of law ~~thirty (~~30~~)~~ **calendar** days after DHCS has acknowledged receipt or upon the date specified in the ~~S~~**s**ubcontract amendment, whichever is later.

3) Whenever contractor submits a subcontract or amendment to a subcontract to DHCS, contractor must identify where specifically in the subcontract each requirement of 42 CFR 460.70(a), (b), (c), and (d) are met.

C. Public Records

Subcontracts entered into by Contractor**,** and all information received in accordance with this subsection**,** will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS to the extent they are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the ~~s~~**S**ubcontractor, stockholders owning more than ~~ten (10)~~ **5** percent of the stock issued by the ~~s~~**S**ubcontractor**,** and major creditors holding more than ~~five (~~5~~)~~ percent of the **Subcontractor's** debt ~~of the subcontractor~~ will be attached to the ~~S~~**s**ubcontract at the time ~~the Subcontract~~ **it** is presented to DHCS.

~~12~~14. Restrictions on Delegation

Existing and applicant **PACE Organizations (**POs)~~'s~~ are not allowed to delegate to a separate entity the operation of an existing or additional (expansion) PACE Center and IDT. DHCS reserves the right to determine whether a PO delegation arrangement involves a separate entity. If DHCS determines that the delegation arrangement involves a separate entity, DHCS may terminate the contract or take other appropriate action, including but not limited to requiring the PO to comply with a ~~corrective action plan~~ **CAP**. PO**'**s may subcontract for the provision of **member** ~~participant~~ service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a **member** ~~participant~~ safely in their home/community are available to the **member** ~~participant~~.

The only exception to the prohibition on the delegation of PACE Center and IDT operations is the On Lok delegation contract with the Institute of Aging originally established on August 1, 1996.

The prohibition on delegation does not prohibit a PO from utilizing alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the **member** ~~participant's~~ home, an inpatient facility, or PACE Center. A PACE **member** ~~participant~~ may receive some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center, and all PACE **members** ~~participants~~ receiving services at an ACS must be assigned to a PACE Center and IDT.

Exhibit A, Attachment 6
Provider Network

15. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, provision 7.

~~13~~16. Nondiscrimination in Provider Contracts

Contractor shall not discriminate for the participation, reimbursement**,** or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable ~~S~~**s**tate law~~,~~ solely on the basis of that license or certification. If Contractor declines to include **an** individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Contractor's provider selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Contractor to contract with providers beyond the number necessary to meet the needs of Contractor's Members; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

Exhibit A, Attachment 7
Provider Relations

1. Exclusivity

Contractor shall not, by use of an exclusivity provision, clause, agreement or in any other manner, prohibit any ~~s~~**S**ubcontractor from providing services to Medi-Cal beneficiaries who are not Members of Contractor's plan. This prohibition is not applicable to contracts entered into between Contractor and Knox-Keene licensed health care plans.

2. Provider Appeals

Contractor shall have a formal process to accept, acknowledge, and resolve Provider Appeals. A provider of medical services may submit to Contractor an Appeal concerning the authorization or denial of a service; denial, deferral or modification of a Prior Authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to all contracting**, subcontracting, and non-contracting** providers ~~whose claim has been denied~~.

Contractor shall implement and maintain procedures to monitor Providers' Appeals, which shall include*:*

A. A procedure to ensure timely resolution and feedback to provider. Contractor shall acknowledge receipt of the Appeal within five days and resolve the Appeal within 30 days or document reasonable efforts to resolve the Appeal.

B. A procedure for systematic aggregation and analysis of the Appeals data and use for Quality Improvement.

C. A procedure to ensure that the Appeal submitted is reported to an appropriate level, i.e., payment or administrative issues versus medical or health care delivery issues.

3. Non-Contracting, Non-Emergency Provider Communication

Contractor shall develop and maintain protocols for payment of claims, and communicating and interacting with non-contracting, non-emergency providers.

4. Provider Manual

Contractor shall issue a ~~P~~**p**rovider ~~M~~**m**anual and updates to **the contracting and subcontracting** providers of ~~C~~**c**overed ~~S~~**s**ervices. ~~The manual shall serve as a source of information to health care providers and shall include, but is not limited~~

~~to, information on Contractor's program, Member and Provider Grievances and Appeals and Contractor's Quality Improvement System (QIS).~~ **That includes information and updates regarding covered services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member grievance, appeal, and State Hearing process. The Contractor's provider manual shall include the following Member rights information:**

A. member's right to a State Hearing, how to obtain a hearing, and representation rules at a State Hearing;

B. member's right to file Grievances and Appeals as well as their requirements and timeframes for filing;

C. availability of assistance in filing;

D. toll-free numbers to file oral Grievances and Appeals; and

E. member's right to request continuation of benefits during an appeal or State Hearing.

5. Provider Training

A. Contractor shall ensure that all Providers receive ~~information or~~ training regarding the PACE program in order to operate in full compliance with the Contract and all applicable federal and ~~S~~**s**tate statutes and regulations. Contractor shall ensure that Provider ~~information or~~ training relates to PACE services, policies, procedures**,** and any modifications to existing services, policies**,** or procedures. **Training shall include methods for sharing information between Contractor, Provider, Member and/or other healthcare professionals.** Contractor shall conduct training ~~or provide information~~ for all providers ~~within ten (10) working days after Contractor places a newly contracted Provider on active status~~ **prior to commencement of Provider service with participant**. Contractor shall ensure that Provider ~~information or~~ training includes information on all Member rights specified in Exhibit A, Attachment 13, ~~Member Services,~~ including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing ~~information or~~ training is ~~provided~~ **conducted** when deemed necessary by either the Contractor or the ~~S~~**s**tate.

Exhibit A, Attachment 7
Provider Relations

B. Contractor shall develop and implement a process to provide information to providers and to train Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for SPDs or persons with or chronic conditions. This process shall include an educational program for Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Providers.

6. Emergency Preparedness

A. Contractor shall establish and annually update an emergency preparedness program that meets all ~~F~~**f**ederal, ~~S~~**s**tate and local emergency preparedness requirements and complies with **42 CFR** ~~Section~~ 460.84 ~~of Title 42 of the Code of Federal Regulations (hereafter referred to as 42 C.F.R. § 460.84)~~. Without limitation, Contractor shall do all of the following:

1) Contractor shall develop and annually update an emergency preparedness plan, in compliance with 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(a), that is based on a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

2) Contractor shall develop and annually update documented policies and procedures, in compliance with 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(b), to manage medical and nonmedical emergencies and disasters identified in its emergency plan.

3) Contractor shall ensure that unexpired food, water, medical supplies, and functioning emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs, along with employees who know how to use the equipment, are on the premise of every ~~S~~**s**ervice ~~S~~**s**ite at all times and readily available.

4) Contractor shall develop and annually update a communication plan in compliance with 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(c).

5) Contractor shall provide initial and annual emergency preparedness training and orientation to all its employees, contracted providers, Members, and others, as required by 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(d), and shall ensure that staff demonstrate a knowledge of emergency

procedures, including informing Members what to do, where to go, and whom to contact in case of an emergency. Contractor shall maintain documentation of all training**; and**.

6) Contractor shall conduct exercises to test, evaluate, and document the effectiveness of its emergency plan at least annually, in compliance with 42 C.F.R. § 460.84(d).

B. If Contractor is part of a health care system consisting of multiple separately certified health care facilities that elect to have a unified and integrated emergency preparedness program, Contractor must ensure compliance with 42 C.F.R. § 460.84(e).

C. Protocols shall be distributed to all Contractor's employees and contracted providers in the Sservice Aarea and shall include, at a minimum, the following:

1) Ddescription of telephone access, triage, and advice systems used by Contractor.;

2) Aa plan contact person or an on-call provider responsible for coordinating services that can be accessed 24 hours per day.:

3) Pprocess for rapid interfacing with emergency care systems.**; and**

4) Rreferral procedures (including after-hours instructions) which emergency department personnel can provide to Medi-Cal Members who present at the **an** emergency department for non-emergency services.

D. Contractor shall ensure that the federal government, State, and Members are held harmless if Contractor does not pay for emergency services.

E. Contractor shall test, evaluate, and document the effectiveness of its emergency and disaster plans at least annually.

F. Contractor shall ensure that the federal government, State, and Members are held harmless if Contractor does not pay for emergency services.

7. Prohibited Punitive Action Against the Provider

Contractor must ensure that punitive action is not taken against the **a** provider who either requests an expedited resolution to a Provider's Appeal or supports a

Exhibit A, Attachment 7
Provider Relations

Member's Appeal. Further, Contract may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient~~:~~**,** for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the enrollee needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decision**s**.

Exhibit A, Attachment 8
Provider Compensation Arrangements

1. Compensation

~~Contractor shall not enter into any Subcontract if the compensation or other consideration which the subcontractor shall receive under the terms of the Subcontract is determined by a percentage of Contractor's payment from DHCS.~~ **Contractor may compensate providers as Contractor and provider negotiate and agree. Unless DHCS objects, compensation may be determined by a percentage of the Contractor's payment from DHCS.** This ~~subsection~~ **provision** shall not be construed to prohibit Subcontracts in which compensation or other consideration is determined **to be** on a Capitation basis.

2. Physician Incentive Plan Requirements

Contractor may implement and maintain a ~~P~~**p**hysician **i**ncentive ~~P~~**p**lan only if~~:~~ **no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member**

~~A. No specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and~~

~~B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR, Section 417.479 are met by Contractor.~~

3. Claims Processing

Contractor shall pay all claims submitted by subcontracting providers in accordance with this section, unless the subcontracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. **C**ontractor shall comply with Section 1932(f)~~,~~ **of** Title XIX~~,~~ **of the** Social Security Act (42 U.S.C. Section 1396u-2(f)), and Health and Safety Code, Section**s** 1371 **through 1371.36.**~~,~~ ~~subject to the following:~~ **Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specific in these sections.**

~~1)~~**B.** Contractor shall pay ~~or deny~~ 90% of **Complete** ~~c~~**C**laims **from practitioners who are in individual or group practices or who participate in health facilities,** ~~for payment submitted by providers for which no further written documentation or substantiation is required~~ within

Exhibit A, Attachment 8
Provider Compensation Arrangements

30 days of **the date of** receipt**, or payment by agreed terms of contract, and 99 percent of all Complete Claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment** ~~by Contractor. Written notice must be given to providers of contested claims within 30 days after receipt of the claim by Contractor. Such notice shall state the reason(s) for contesting the claim. Contractor agrees that failure to provide timely notification to a provider of a contested claim means that the claim is not being contested and is subject to the requirements for paying uncontested claims~~.

~~2) Contractor shall ensure that 100% of claims for payment submitted by providers for which no further written documentation or substantiation is required are paid or denied within 45 State working days after receipt~~.

~~B~~**C**. Contractor shall maintain procedures for pre**-**payment and post**-**payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.

~~C~~**D**. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to**:** comply with applicable federal and ~~S~~**s**tate law and regulations **and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.**

4. Prohibited Claims

A. Except in specified circumstances, Contractor and any of its ~~A~~**a**ffiliates and subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a **Medi-Cal** Member. Collection of claim may be made under those circumstances described in **Welfare and Institutions Code section 14452.6,** Title 22, CCR, ~~S~~**s**ections ~~53866,~~ 53220, and 53222.

B. Contractor shall not hold Members liable for Contractor's debt if Contractor becomes insolvent. In the event Contractor becomes insolvent, Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

Exhibit A, Attachment 8
Provider Compensation Arrangements

5. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Programs

A. FQHCs Availability and Reimbursement Requirement

If FQHC or RHC services are not available in the Contractor's provider network Contractor shall reimburse non-contracting FQHCs and RHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC.

B. Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Subcontracts. Contractor shall certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), as amended by Chapter 894, Statutes of 1998, FQHC and RHC Subcontract terms and conditions are the same as offered to other subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHCS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and Federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

To the extent that Indian Health Programs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to Subcontracts with Indian Health Programs.

C. Indian Health Programs

Contractor shall reimburse Indian Health Programs for services provided to Members who are qualified to receive services from an Indian Health Program as set forth in 42 USC Section 1396u-2(h)(2), Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009, and, insofar as they do not conflict with Federal law or

regulations, the reimbursement options set forth in Title 22 CCR Section 55140(a).

~~5~~6. Sexually Transmitted Disease (STD)

Contractor shall reimburse ~~l~~**L**ocal ~~h~~**H**ealth ~~d~~**D**epartments **(LDHs)** and non-contracting family planning providers at no less than the appropriate Medi-Cal **Fee For Service (**FFS**)** rate, for the diagnosis and treatment of a STD episode, as defined in ~~MMCD~~ **Medi-Cal Managed Care** Policy Letter No. 96-09. Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

~~6~~7. HIV Testing and Counseling

Contractor shall reimburse ~~local health departments~~ **LHDs** and non-contracting family planning providers at no less than the Medi-Cal FFS rate for HIV testing and counseling. Contractor shall provide reimbursement only if ~~local health departments~~ **LHDs** and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Contractor.

~~7~~8. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

A. Emergency Services: Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek ~~e~~**E**mergency ~~s~~**S**ervices.

B. Contractor may not limit what constitutes an ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollees ~~p~~**P**rimary ~~c~~**C**are ~~p~~**P**rovider **(PCP)**, the plan, or DHCS of the enrollee's screening and treatment within **ten** ~~10~~ calendar days of presentation for emergency

services. A Member who has an ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or **to** stabilize the patient.

C. Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor, or the Member is stabilized sufficiently to permit discharge. The attending emergency ~~p~~**P**hysician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

D. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

E. For all non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 3~~. Claims Processing,~~ above, and **Title** 42 U**.**S**.**C**.** Section 1396u-2(b)(2)(D).

~~F. Contractor shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting provider based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Contractor shall not limit what constitutes an Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.~~

~~G~~**F.** In accordance with Title 28, CCR, ~~S~~**s**ection 1300.71.4, Contractor shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization will be

deemed approved. Contractor is financially responsible for post-stabilization service payment as provided in sub-provision C above.

~~H~~**G.** Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of ~~W&I~~ **Welfare and Institutions** Code ~~S~~**s**ection 14454 and Title 22, CCR, ~~S~~**s**ection 53620 et. seq., except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with ~~W&I~~ **Welfare and Institutions** Code ~~S~~**s**ections 14454(c) and 14115.5, and Title 22, CCR, Section 53702.

~~I~~**H.** Post Stabilization Services: **Post-stabilization care means services provided subsequent to an emergency that a treating physician views as medically necessary after an Emergency Medical Condition has been stabilized. They are not emergency services, which Contractor is obligated to cover. Rather, they are non-emergency services that Contractor should approve before they are provided outside of PACE plan. Contractor must establish and maintain a written plan which provides for coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions is met:**

1) the services are preapproved by the PACE organization; or

2) the services are not preapproved by the PACE organization because the PACE organization did not respond to a request for approval within one hour after being contacted or cannot be contacted for approval.

Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR, ~~Section~~ 422.113(c). Contractor is financially responsible for post-stabilization services obtained within or outside Contractor's network that are pre-approved by a plan provider or other entity representative. Contractor is financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other Contractor representative, but administered to maintain the enrollee's stabilized

condition within **one** ~~1~~ hour of a request to Contractor for pre-approval of further post-stabilization care services.

~~J.~~**I.** Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating ~~p~~**P**hysician cannot reach an agreement concerning the enrollee's care and a plan ~~p~~**P**hysician is not available for consultation. In this situation, Contractor must give the treating ~~p~~**P**hysician ~~the~~ **an** opportunity to consult with a plan ~~p~~**P**hysician and the treating ~~p~~**P**hysician may continue with care of the patient until a plan ~~p~~**P**hysician is reached or one of the criteria of 42 CRF, ~~Section~~ 422.~~133~~ **113**(c)(3) is met.

~~K.~~**J.** Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan ~~p~~**P**hysician with privileges at the treating hospital assumes responsibility for the Member's care, a plan ~~p~~**P**hysician assumes responsibility for the Member's care through transfer, a plan representative and the treating ~~p~~**P**hysician reach an agreement concerning the enrollee's care~~:~~**,** or the enrollee is discharged.

~~L.~~**K.** Consistent with 42 CFR, ~~S~~**s**ections 438.114(e), 422.113(c)(2), and 422.214**,** Contractor is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medicare rate if the member is Medicare eligible or at the hospital's Medi-Cal FFS payment amounts if the member is eligible for Medi-Cal only for general acute care inpatient services rendered by a non-contracting hospital, unless a lower rate is agreed to in ~~a~~ writing **and** signed by the hospital.

1) For the purposes of this Paragraph L, the Medi-Cal payment amount for dates of service when the post-stabilization services were rendered shall be in the Medi-Cal payment amounts that are:

a) Published in the annual All Plan Letter issued by the Department in accordance with California Welfare and Institutions Code section 14091.3, which for the purposes of this Paragraph L ~~This provision~~ shall apply to all ~~general~~ acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective

Exhibit A, Attachment 8
Provider Compensation Arrangements

Provider Contracting Program (**Welf. & Inst. Code**, ~~W & I Section~~ § 14081 et seq.), less any associated direct or indirect medical education payments to the extent applicable**, which Item (a) shall be applicable until it is replaced by the implementation of the payment methodology in Item (b) below.**

b) Established in Welfare and Institutions Code section 14105.28, upon the Department's implementation of the payment methodology based on diagnosis-related groups, which for the purposes of this Paragraph K shall apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure (CPE) Basis methodology (Welf. and Inst. Code § 14166. et. seq.), less any associated direct or indirect medical education payments to the extent applicable

2) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this provision shall constitute payment in full **under this Paragraph L,** and ~~the payment~~ shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by **California Code of Regulations section** 51536 shall not have any effect on payments made by Contractor pursuant to this ~~Subprovision~~ **paragraph** L.

Exhibit A, Attachment 9
Access and Availability

1. General Requirement

A. **Contractor shall establish and implement a written plan to furnish care that meets the needs of each member in all care settings 24 hours a day, every day of the year. Contractor shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.**

B. **The PACE benefit package for all members includes the following:**

1) all Medicare-covered items and services;

2) all Medicaid-covered items and services, as specified in the State's approved Medicaid plan; and

3) other services determined necessary by the interdisciplinary team to improve and maintain the member's overall health status.

C. **While enrolled in the Contractor's PACE plan, the member must receive Medi-Cal benefits solely through Contractor's PACE organization. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles copayments, coinsurance, or other cost-sharing do not apply.**

D. **Contractor must operate at least one PACE center either in, or contiguous to, its defined service area with sufficient capacity to allow routine attendance by members. The PACE Center must comply with the physical environment requirements of 42 CFR 460.72.**

E. **Contractor must ensure accessible and adequate services to meet the needs of its members. If necessary, Contractor must increase the number of PACE centers, staff, or other PACE services.**

F. **If Contractor operates more than one center, each PACE center must offer the full range of services and have sufficient staff to meet the needs of members.**

G. **At a minimum, the following services must be furnished at each PACE center:**

Exhibit A, Attachment 9
Access and Availability

a. Primary care, including physician and nursing services;

b. Social services;

c. Restorative therapies, including physical therapy and; occupational therapy;

d. Personal care and supportive services;

e. Nutritional counseling;

f. Recreational therapy; and

g. Meals.

~~A.~~**H.** Contractor shall ensure that each Member has a ~~Primary Care Provider~~**(PCP~~)~~** who is available ~~and physically present at the~~ ~~Service Site~~ for sufficient time to ensure access for the assigned Member upon request by the Member or when medically required and to ensure **c**ase **m**anagement of the Member on an on-going basis. This requirement does not preclude an appropriately licensed professional from being a substitute for the ~~Primary Care Provider~~ **PCP** in the event of vacation, illness or other unforeseen circumstances.

~~B.~~**I.** Contractor shall ensure Members access to all Medically Necessary specialists through staffing, subcontracting, or referral. Contractor shall ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services shall be provided.

J. Contractor shall ensure that telehealth is recognized as a legitimate means by which a member may receive health care services from a health care provider without in-person contact with the health care provider, pursuant to the provisions of Welfare and Institutions Code section 14594.

a. Contractor shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and Contractor, and between Contractor and its participating providers or provider groups.

b. **Contractor shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the PACE organization, and between the PACE organization and its participating providers or provider groups.**

c. **Contractor may not require the use of telehealth when the health care provider has determined that it is not appropriate**.

2. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, **routine specialty referral appointments,** emergency care, adult ~~i~~**I**nitial ~~h~~**H**ealth ~~a~~**A**ssessments **(IHAs),** and procedures for obtaining appointments with specialists. For purposes of this provision, "Urgent Care" means "on-site" Urgent Care**. Contractor shall also include procedures for follow-up on missed appointments.**

B. Urgent Care

Contractor shall ensure that a Member needing Urgent Care shall be seen within 24 hours upon request. For purposes of this provision, "Urgent Care" means "on-site" Urgent Care.

C. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and

return), and ~~in obtaining various types of appointments~~ **time to obtain various types of appointments indicated in Paragraph A**.

D. Telephone Procedures

Contractor shall **require providers to** maintain a procedure for triaging Members' telephone calls, providing telephone medical advice **(if it is made available**), and accessing telephone interpreters.

E. After Hours Calls

At a minimum, Contractor shall ensure that a Physician or ~~Registered Nurse~~ **an appropriate licensed professional** under his **or** ~~(~~her~~)~~ supervision shall be available for after-hours calls.

F. Sensitive Services

Contractor shall implement and maintain procedures to ensure confidential access in a timely manner to Sensitive Services without Prior Authorization for all Members.

1) Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through ~~local health department (~~LHD~~)~~ clinics, family planning clinics or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode.

2) HIV Testing and Counseling

a. Members may access confidential HIV counseling and testing services through the Contractor's provider network and through out-of-network local LHD and family planning providers.

b. Contractor shall develop, implement and maintain policies and procedures for the treatment of HIV infection and AIDS. Contractor shall submit any changes in these policies and procedures to DHCS at least 30 days prior to their implementation.

Exhibit A, Attachment 9
Access and Availability

G. Access for Disabled Members

Contractor's facilities shall comply with the requirements of Title III~~I~~ of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

H. Unusual ~~or Seldom Used~~ Specialty Services

Contractor shall arrange for the provision of Unusual ~~or Seldom Used~~ Specialty Services from specialists outside the network **if unavailable within Contractor's network,** when **it is** determined ~~M~~**m**edically ~~N~~**n**ecessary.

3. Emergency Care

~~Contractor shall ensure that a Member with an Emergency Medical Condition as defined in Exhibit E, Attachment 1, Definitions, shall be seen immediately and Emergency Services will be available and accessible within the Service Area 24 hours a day. Contractor shall ensure adequate follow-up care for those Members who require non-emergency care and who are denied services in the emergency room.~~

Contractor shall establish and maintain a written plan to handle emergency care as required by 42 CFR 460.100. The plan must ensure that CMS, the State, and PACE members are held harmless if Contractor does not pay for emergency services.

Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach Contractor or one of its contract providers, would cause risk of permanent damage to the member's health. Emergency services include inpatient and outpatient services that meet the following requirements:

A. Are furnished by a qualified emergency services provider, other than the Contractor or one of its contract providers, either in or out of the Contractor's service area;

B. Are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of

health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) Serious jeopardy to the health of the member;

2) Serious impairment to bodily functions;

3) Serious dysfunction of any bodily organ or part.

Contractor must ensure that the member or caregiver, or both, understand when and how to get access to emergency services and that no prior authorization is needed.

Contractor must provide for the following:

1) An on-call provider, available 24–hours per day to address member questions about emergency services and respond to requests for authorization of urgently needed out-of-network services and post stabilization care services following emergency services.

2) Coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:

a. The services are preapproved by Contractor; and

b. The services are not preapproved by Contractor because Contractor did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

~~A~~**C**. Contractor shall cover Emergency **Medical** Services without Prior Authorization **pursuant to California Code of Regulations title 28 section 1300.67(g), and ~~s~~ection 53216. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7)**.

~~B~~**D**. Contractor shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care.

Exhibit A, Attachment 9
Access and Availability

~~C~~**E**. Contractor shall ensure that a plan or contracting Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

4. Changes in ~~Availability or~~ Location of ~~Covered Services~~ PACE Center

~~Contractor shall obtain DHCS approval prior to making any substantial change in the availability or location of services to be provided under this Contract except in the case of unforeseen circumstances. A proposal to change the location of services or to reduce their availability shall be given to the DHCS at least 30 days prior to the proposed effective date.~~

Contractor shall provide notification to DHCS at least 180 calendar days prior to making any substantial change in the location of PACE Center. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5. ~~Civil Rights Act of 1964~~ Nondiscrimination and Language Access

A. Contractor shall ensure compliance with Section 1557 of the Affordable Care Act of 2010 and any implementing regulations (42 U.S. Code § 18116; 45 C.F.R. Section 92) that prohibit any entity operating a health program or activity, any part of which receives federal financial assistance, from discriminating against persons based on sex, race, color, national origin, age or disability. Contractor shall comply with All Plan Letter (APL) 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (June 30, 2017), including any superseding All Plan Letter. Contractor shall use an up-to-date template Notice of Non-Discrimination to be provided by DHCS and shall ensure that its Notice of Non-Discrimination contains contact information for the DHCS Office of Civil Rights and instructions for filing a discrimination complaint directly with the DHCS Office of Civil Rights.

~~A~~**B**. Contractor shall ensure compliance with Title ~~6~~ **VI** of the Civil Rights Act of 1964 **and any implementing regulations** (42 U.S.C. ~~Section~~ 2000d, 45 C.F.R. ~~Part~~ **section** 80) ~~which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, or national origin~~. **Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members or potential**

members through provision of high quality interpreter and linguistic services.

~~B. Contractor shall provide 24-hour access to interpreter services for limited English proficient Medi-Cal Members to health care services within Contractor's network either through telephone language services or interpreters.~~

C. Contractor shall ensure compliance with California nondiscrimination laws, including Section 14029.91 of the Welfare and Institutions Code and Section 11135 of the Government Code.

6. Cultural and Linguistics Program

Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall be accountable for the quality of health care delivered, whether preventive, primary, specialty, emergency or ancillary care services regardless of the number of contracting or subcontracting layers between Contractor and the individual practitioner delivering care to the Member.

A. Linguistic Capability of Employees

Contractor shall assess, identify**,** and report the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

B. Group Needs Assessment

1) Contractor shall ensure that a group needs assessment of Members is completed. This group needs assessment shall be conducted in conjunction with the health education group needs assessment, and shall include identification of linguistic needs of the groups that speak a primary language other than English and of all cultural groups within the Service Area.

2) The findings of the assessment shall be maintained as a program description entitled "Cultural and Linguistic Services Program". In the program description, Contractor shall summarize the methodology and findings of the group needs assessment of the linguistic needs of non-English speaking groups, as well as the cultural needs of all plan Members, and outline the proposed services to be implemented to address the timeline for

implementation with milestones, and the responsible individual. Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan.

3) The results of the group needs assessment shall be considered in the development of any Marketing materials prepared by Contractor.

C. Program Implementation and Evaluation

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Service Program.

7. Linguistic Services

A. ~~Contractor shall provide linguistic services to Members and potential Members residing in Contractor's Service Area who indicate their primary language as other than English.~~
Contractor shall ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential Members receive 24-hour oral interpreter services at all key points of contact, as defined in paragraph D. of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor **shall comply with 42 CFR 438.10(d)(4) and** provide**, at a minimum,** the following **linguistic** services **at no cost to Medi-Cal** ~~to those~~ Members ~~at these key points of contact~~ **or potential members**:

~~1) Key Points of Contact~~

~~a. Medical: Advice and Urgent Care telephone, face to face outpatient encounters with health care providers, including pharmacists.~~

~~b. Non-medical: Membership services, orientations, and when scheduling appointments.~~

Exhibit A, Attachment 9
Access and Availability

1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those who speak the threshold or concentration- standards languages.

~~2) Types of Services~~

~~a. Interpreters, signers or bilingual providers and provider staff at all Services Sites. These services shall be provided in all languages spoken by Members and not limited to those that speak the threshold concentration standard languages.~~

~~b. Translated written informing materials, including but not limited to the Member Enrollment Agreement Terms and Conditions, enrollee information, welcome packets, and Marketing information.~~

2) Fully translated written informational materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members who speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

3)~~c~~. Referrals to culturally and linguistically appropriate community service programs.

4)~~d~~. ~~Telecommunications Device for the Deaf (TDD).~~

~~TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general.~~

Auxiliary Aids and Services such as California Relay, Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) and American Sign Language.

Exhibit A, Attachment 9
Access and Availability

C. Contractor shall provide translated materials to the following population groups within its Service Area as determined by DHCS:

1) A population group of Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English, and who meet a numeric threshold of 3,000 or five percent (5%) of the Medi-Cal population, whichever is lower.

2) A population group of Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two continuous zip codes.

D. Key points of contact include:

1) medical care settings: telephone, advice, and urgent care transactions, and outpatient encounters with health care providers including pharmacists; and

2) non-medical care setting: Member services, orientations, and appointment scheduling.

8. Participant Advisory Committee

Contractor shall establish a participant advisory committee in accordance with 42 CFR, Section 460.62. Contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who may or may not speak a primary language other than English and cultural competency.

~~**9. Healthcare Surge Events**~~

~~Contractor shall develop and implement policies and procedures to mitigate the effects of natural, manmade, or war-caused disasters involving emergency situations and/or broad healthcare surge events greatly impacting Contractor's health care delivery system. Contractor's policies and procedures shall ensure that Contractor will pro-actively cope with emergency situations and/or healthcare surge events resulting from such disasters or states of emergency, and shall include but are not limited to protecting enrollees, if necessary, by keeping Covered Services available to Members; keeping the revenue stream flowing to Providers In order to keep Covered Services available; transferring Members~~

~~from Provider-to-Provider in the event of diminished plan capacity to keep Covered Services available; and promptly notifying DHCS of the status of the availability and locations of Covered Services, and/or Providers.~~

9. Out-of-Network Providers

If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment.

Exhibit A, Attachment 10
Scope of Services

1. Covered Services

A. Contractor shall provide or arrange ~~and pay~~ for~~,~~ **all Medically Necessary** Covered Services ~~to any and all~~ **for** Members**. Covered services are those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract** ~~needing such services. Contractor shall ensure that the Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under FFS~~.

B. **Medi-Cal benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.**

C. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

2. Medically Necessary Services

Contractor shall provide or arrange for all Medically Necessary Covered Services for Members as stated in Exhibit E, Attachment 1, ~~Definitions~~, provision 26A. Contractor shall ensure that the Medical Necessity of Covered Services is determined through utilization control procedures established in accordance with Exhibit A, Attachment 5, ~~Utilization Management,~~ provisions 1 and 3, unless specific utilization control requirements are included as terms of the Contract under sections applicable to specific services. However, no utilization control procedure or any other policy or procedure used by Contractor shall limit services Contractor is required to provide under this Contract.

For purposes of this Contract, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. (Cal. Code Regs., title 22, 51303, subd.(a).)

3. Initial Health Assessments

Exhibit A, Attachment 10
Scope of Services

Contractor shall conduct an initial comprehensive assessment by the IDT on each Member**, periodic reassessments, and unscheduled reassessments** as required by 42 CFR, ~~Section~~ 460.104. This assessment shall include a complete history and physical examination, and **a** health education behavioral assessment. **The IDT must promptly develop a comprehensive plan of care for each member, implement the plan of care, and evaluate the plan of care in compliance with 42 CFR 460.106.**

4. Services for Members

A. Contractor shall ensure that the performance of the initial complete history and physical exam for Members includes, but is not limited to:

1) ~~B~~**b**lood pressure**:** persons who are normotensive shall have blood pressure measurements at least annually~~.~~**;**

2) height and weight;

~~2~~**3**) ~~C~~**c**holesterol**;** total cholesterol shall be measured at least once every ~~5~~ **five** years~~.~~**;**

~~3~~**4**) ~~C~~**c**linical breast examination**;** ~~- w~~**W**omen shall have annual clinical breast examination**s.;**

~~4~~**5**) ~~M~~**m**ammogram**;** all women ~~over age 50~~ shall have a screening mammogram every ~~1~~ **one** to ~~2~~ **two** years, concluding at age 75 unless pathology has been demonstrated;~~.~~

~~5~~**6**) ~~P~~**p**ap ~~S~~**s**mear**;** ~~- beginning at the age of first sexual intercourse~~, ~~p~~**P**ap smears shall be performed every one to three years, depending on the presence or absence of risk factors. Regular screening may be discontinued after age 65 in those ~~participants~~ **members** who have had regular screening with consistently normal results**; and**~~.~~

~~6~~**7**) ~~T~~**t**uberculosis (TB) screening**:** ~~-~~ all Members shall receive testing upon enrollment and annual screening**s** shall be performed as a part of the history and physical~~.~~**, including a Mantoux skin test on all persons determined to be high risk.**

Exhibit A, Attachment 10
Scope of Services

B. Member Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for Members.

1) Contractor shall implement and maintain The Guide to Clinical Preventive Services, a report of the U.S. Preventive Service Task Force (USPSTF) as the minimum acceptable standard for Member Preventive Health Services. The preceding are a core set of preventive services that shall be provided to all asymptomatic, healthy Members, age 21 and older. (This is not an inclusive list of all appropriate preventive services. The presence of risk factors in individual patients shall affect the type and quantity of preventive services that may be appropriate. A given patient may need additional services or core services at more frequent intervals).

2) Contractor shall provide managed health and other diagnostic and treatment services utilizing the IDT approach to assess and evaluate Member needs, initiate and coordinate required care and otherwise provide effective Case Management for each Member. Contractor shall accept responsibility for management of all health care costs and services for each Member, except for those services which are specifically excluded as stated Exhibit E, Attachment 1, provision 26B.

C. Immunizations

1) Contractor is responsible for assuring that all Members are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

2) Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

~~1~~**3**) Appropriate documentation shall be entered in the Member's Medical Record that indicates all attempts to provide immunization(s), instructions as to how to obtain necessary immunizations, or proof of prior immunizations or proof of voluntary refusal of vaccines in the form of a signed statement by the

Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

~~2) In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the Initial Health Assessment (IHA), other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment and subsequent periodic health assessments.~~

5. Services for All Members

A. Health Education

1) Contractor shall implement and maintain a **health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members** ~~system for providing Member health education services, clinical preventive services, health education and promotion and patient education and counseling. The system shall utilize one to one and group interventions, written and audio-visual materials. Contractor shall ensure that the services are provided directly by Contractor or through Subcontracts or formal agreements with other providers specializing in health education services~~.

2) Contractor shall maintain administrative oversight of the ~~program~~ **health education system through a combination of services equivalent to the services of a** ~~by a designated~~ **qualified full-time** health educator.

3) Contractor shall **provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population** ~~arrange for the timely referral and coordination of those services to which Contractor or subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate, and ensure provision of services through referrals at no additional expense to DHCS~~.

Exhibit A, Attachment 10
Scope of Services

4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.

5) Contractor shall ensure that health education materials are written at the sixth grade **reading** level and are culturally and linguistically appropriate for the intended audience.

6) Contractor shall maintain a health education system that ~~includes, at a minimum, the following services~~ **provides education interventions addressing the following health categories and topics**:

a. risk-reduction and healthy lifestyles; tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV; nutrition, weight control, and physical activity; and

b. self-care and management of health conditions: asthma, diabetes; and hypertension.

~~a. Member Education~~

~~(1) Use of Clinical Preventive Services~~

~~(2) Promote Appropriate Use of Plan Services~~

~~b. Clinical Preventive Services, Education, and Counseling~~

~~(1) Nutrition~~

~~(2) Tobacco Prevention and Cessation~~

~~(3) HIV/STD Prevention~~

~~(4) Exercise~~

~~(5) Dental~~

~~(6) Skin Care~~

~~(7) Hygiene~~

Exhibit A, Attachment 10
Scope of Services

~~(8) Injury Prevention~~

~~(9) Immunizations~~

~~(10) Vision~~

~~(11) Hearing~~

~~c. Patient Education and Clinical Counseling~~

~~Diabetes~~

~~(2) Asthma~~

~~(3) Hypertension~~

~~(4) Substance Abuse~~

~~(5) Tuberculosis~~

~~(6) Inpatient - Condition Specific~~

~~(7) Other Outpatient~~

7) Contractor shall develop, implement, and maintain standards, policies and procedures**,** and ensure provision of the following:

a. Member orientation, education regarding health promotion, personal health behavior, and patient education and counseling~~.~~**:**

b. Provider education on health education services~~.~~**; and**

c. Individual health education behavioral assessment, referral, and follow-up.

8) Contractor shall maintain health education policies and procedures, and standards and guidelines**,**~~;~~ conduct appropriate levels of program evaluation**,**~~;~~ and monitor performance by IDT members providing health education services to ensure effectiveness.

Exhibit A, Attachment 10
Scope of Services

9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor shall ensure that individual age appropriate health education behavioral assessments are conducted on all Members within ~~90~~ **60 calendar** days of Enrollment to identify high-risk behaviors of individual plan Members, to assist providers in prioritizing individual health education needs of their assigned patients related to lifestyle, behavior, environment, and cultural linguistic background and to assist providers in initiating and documenting focused health education interventions, referrals and follow-up. ~~Refer to MMCD Policy Letter 99-07 for details.~~ Contractor may modify the tool to fit its population.

~~11) Contractor shall maintain a system for informing Members about health education contributions they can make toward the maintenance of their own medical and dental health.~~

~~12) Contractor shall ensure coordination and integration of the health education system with the Quality Improvement program.~~

~~13) Contractor shall conduct a group needs assessment of its Members to determine health education needs, including literacy level. If not previously submitted, Contractor shall submit to DHCS a report summarizing the methodology, findings, proposed services, key activities, timeline for implementation, and the responsible individuals.~~

11) Contractor shall cover and ensure provision of Comprehensive Case Management including coordination of care services as described in Exhibit A, Attachment 11.

B. Nursing Facility Services

1) Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in Facilities providing the appropriate level of care commensurate with the Member's medical needs. These facilities include Skilled Nursing Facilities and Intermediate Care Facilities.

2) Contractor shall base decisions on the appropriate level of care on the determination of whether the Member can live in a community setting without jeopardizing his or her health or safety and not inconsistent with the definitions set forth in **California Code of Regulations** ~~T~~title 22, ~~CCR~~, ~~S~~sections 51118, 51120, 51120.5, 51121, and 51124.5, and the criteria for admission set forth in ~~T~~title ~~22, CCR~~, ~~S~~sections 51335 and 51334.

3) Contractor shall reimburse contracted providers at rates that are not less than Medi-Cal Fee-For Services (FFS) rates, as published and revised by DHCS, including retroactive payment of any additional rate increment based on DHCS retroactive rate adjustments, for equivalent services for the date(s) of service.

C. Vision Care**:** ~~-~~Lenses

Contractor shall ensure a vision care services system, consistent with good professional practice, which provides that a Member may be seen initially by ~~either~~ **any** of the following:

1) An optometrist or an ophthalmologist.

2) A PCP before referral to an optometrist or an ophthalmologist.

D. Mental Health Services

1) Contractor shall implement and maintain a mental health services system consistent with good professional practice, which provides that a Member may be seen initially by either of the following:

a. Psychiatrist or psychologist, or a psychiatric social worker who is working under qualified supervision**; or** ~~.~~

b. A PCP before referral to a mental health service provider.

2) Contractor shall implement and maintain policies and procedures for mental health services to include inpatient and outpatient services as determined ~~m~~**M**edically ~~n~~**N**ecessary by the PCP.

E. Tuberculosis (TB)

1) TB screening, diagnosis, treatment**,** and follow-up are covered under ~~the~~ **this** Contract. Contractor shall provide TB care and

treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

2) Contractor shall coordinate with LHDs in the provision of direct observed therapy as required in Exhibit A, Attachment 11, provision 16 and Attachment 12.

F. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including, but not limited to, Title 22, CCR, Section 53214, ~~and~~ W&I Code, Section 14185**, Title 42, CFR, Sections 460.90, 460.92, 460.3 and 460.84. PACE plans are not subject to the requirements of the California Executive Order N-01-19, transitioning all pharmacy services for Medi-Cal managed care to a fee-for-service benefit, unless as directive making PACE plans subject to Executive Order N-01-19 is issued. If such a directive is issued, then PACE plans must comply with the terms of that directive, the Executive Order, and any implementing authorities.**

~~1~~**2**) As a minimum, such pharmaceutical services and drugs shall be available to Members during ~~Service Site~~ **PACE Center business** hours.

~~2~~**3**) Contractor shall provide a response to a Prior Authorization request from a Contracting provider for a Member's prescription drugs within 24 hours or one business day.

~~3~~**4**) Contractor ,also shall allow a Member to continue use of a single source drug which was part of a prescribed therapy in effect immediately prior to the Member's enrollment even if the drug is not covered by Contractor, until the drug is no longer prescribed by the Contracting provider.

~~4~~**5**) When the course of treatment provided to a Member by a Contracted provider under emergency circumstances requires the use of drugs, at least a 72-hour supply of a covered outpatient drug or a sufficient quantity of such drugs shall be provided to the

Member to last until the Member can reasonably be expected to have a prescription filled.

~~5)~~**6)** Contractor shall develop and implement effective drug utilization reviews and treatment outcomes to optimize the quality of pharmacy services.

7) Contractor's process should also ensure that drug utilization reviews are appropriately conducted and that pharmacy service and drug utilization Encounter Data are provided to DHCS on a monthly basis.

6. Transportation

Transportation services must be provided in compliance with 42 CFR 460.76.

7. Dietary Services

Dietary services are covered as set forth in 42 CFR 460.78

Exhibit A, Attachment 11
Case Management and Coordination of Care

~~**1. Comprehensive Case Management Including Coordination of Care Services**~~

~~A. Contractor shall ensure the provision of Comprehensive Medical Case Management Services to each Member.~~

~~B. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including, but not limited to, all Medically Necessary services delivered both within and outside Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.~~

~~2~~1. Interdisciplinary Team Case Management

A. Contractor shall provide managed health and other diagnostic and treatment services utilizing the IDT approach to comprehensively assess and evaluate Member needs, initiate and coordinate required care, and otherwise provide effective Case Management for each Member **in compliance with 42 CFR 460.102, 460.104, 460.106, 460.114, 460.92, and 460.98**.

B. Contractor shall accept responsibility for management of all health care costs and services for each Member, except for those services which are specifically excluded as stated in Exhibit E, Attachment 1, provision 26B.

~~3~~2. Nursing Facility Level of Care

Contractor's IDT shall be responsible for assessing Members for meeting skilled or intermediate nursing facility level of care criteria in accordance with **California Code of Regulations,** ~~T~~title 22, ~~CCR,~~ Sections 51334 and 51335. Evaluation and determination of Members prior to Enrollment in Contractor's plan shall be determined solely by DHCS as meeting the level of care requirements.

43. Infection Control

A. Contractor shall implement and maintain an effective plan for the surveillance, prevention, and control of infection **in compliance with 42 CFR 460.74**. Contractor shall ensure that this plan shall include the scope (both patient care and support services), the persons responsible, the policies and procedures and frequency of review (at least every 2 years), the role and responsibilities of each service, the monitoring activities, and approval by the **g**~~G~~overning **b**~~B~~ody.

Exhibit A, Attachment 11
Case Management and Coordination of Care

B. Contractor shall implement and maintain policies for prevention and control of infection transmission in patients and personnel which include:

1) ~~T~~**t**he application of universal precaution procedures~~.~~**;**

2) ~~T~~**t**he availability of adequate infection control devices and supplies in the patient areas~~.~~**;**

3) ~~I~~**i**nfectious or bio-hazardous waste disposal procedures complying with applicable ~~S~~**s**tate and federal regulations~~.~~**;**

4) ~~I~~**i**solation precautions and procedures~~.~~ **;**

5) ~~C~~**c**leaning and sterilization methods, agents, and schedules, including maintenance of autoclave, spore testing, storage of sterile packs, etc.; and

6) ~~T~~**t**raining and continuing education of all personnel.

C. Contractor shall implement and maintain a procedure for reporting infectious diseases to public health authorities as required by **s**~~S~~tate law.

D. Contractor shall ensure that its infection control policies are maintained by its ~~s~~**S**ubcontractors.

E. Contractor shall ensure the review of patient infections that present the potential for prevention or intervention to reduce the risk of future occurrence.

~~5~~4. Inpatient Care

Contractor shall implement and maintain procedures to monitor Quality of Care provided in an inpatient setting to its Members. If Contractor delegates the QI functions to hospitals, Contractor shall maintain procedures to monitor the delegated function, including review of services provided by its Physicians within the hospital.

5. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or

Exhibit A, Attachment 11
Case Management and Coordination of Care

programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6. Dental

Contractor shall ensure a dental care services system, consistent with good professional practice that guarantees Members direct access to dental care as determined by the IDT.

7. Immunization Registry Reporting

Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's IHA and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and federal laws.

8. Erectile Dysfunction (ED) Drugs and Other ED Therapies

ED drugs and other ED therapies are excluded from coverage under Medi-Cal unless such drug is used to treat a condition other than sexual or erectile dysfunction, and as approved by the Food and Drug Administration. ED drugs and other ED therapies are covered under this contract if they are determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, as provided under 42 CFR section 460.92(c).

Exhibit A, Attachment 12
Local Health Department Coordination

~~THIS ATTACHMENT INTENTIONALLY LEFT BLANK~~

1. Subcontracts

If the Contractor makes referrals to LHDs for public health services listed in paragraphs A through D below, Contractor shall negotiate in good faith and execute a Subcontract with the LHD in each county that is covered by this Contract in each county zip code service area that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the LHD and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts.

A. STD services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 10, by DHCS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

B. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, provision 11.

C. Immunizations as specified in Exhibit A, Attachment 8, provision 12.

D. To the extent that Contractor does not meet this requirement on or before four months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Local Mental Health Plan Coordination

A. If the Contractor makes referrals to Medi-Cal local mental health plans for specialty mental health services, Contractor shall negotiate in good faith and execute a Subcontract with the MHP in each county zip code service area that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the MHP and the Contractor, including

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Exhibit A, Attachment 12
Local Health Department Coordination

exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts. The subcontract shall address:

1) protocols and procedures for referrals between Contractor and the MHP;

2) protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

3) protocols for the delivery of mental health services within the PACE IDT scope of practice;

4) protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.

5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

a) Pharmaceutical services and prescription drugs;

b) Laboratory, radiological and radioisotope services;

c) Emergency room facility charges and professional services;

d) Emergency and non-emergency medical transportation;

e) Home health services; and

f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition; and

Exhibit A, Attachment 12
Local Health Department Coordination

7) Procedures to resolve disputes between Contractor and the MHP.

Exhibit A, Attachment 13
Member Services

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement, and maintain **a formal Participant Bill of Rights approved by CMS, in compliance with 42 U.S.C. 1395eee(b)(2)(B), 42 CFR 460.32(a)(5), 460.110, and 460.112, which includes** written policies that address the Member's rights and responsibilities and shall communicate these to its employees, Members, **providers, and, upon request, potential members** ~~and contracted providers~~.

Contractor assures that the rights and protections of the Participant Bill of Rights will be provided, as required by 42 CFR 460.32(a)(5).

Contractor shall have established documented procedures to respond to and rectify a violation of a participant's rights, as required by 42 CFR 460.118.

Contractor must have written policies and implement procedures to ensure that the participant, his or her representative, if any, and staff understand these rights, as required by 42 CFR 460.116.

1) Contractor's written ~~policy regarding Member rights~~ **Participant Bill of Rights** shall include~~, but not be limited to,~~ the following:

a. ~~Member has the right~~ to be treated with ~~dignity and~~ respect, **giving due consideration to the Member's right to** ~~be afforded~~ privacy and **the need to maintain** confidentiality **of the Member's medical information** ~~in all aspects of care, and to be provided humane care from all Contractor's employees and providers at all times and under all circumstances~~.

b. ~~Member has the right~~ not to be discriminated against in the delivery of required services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or source of payment.

~~c. Member has the right to be provided with information about the organization and its services, to be able to choose a Primary Care Physician if another PCP is employed by Contractor, to participate in decision making regarding their~~

~~own health care, including the right to refuse treatment and be informed of the consequences of the decisions, to voice Grievances about the organization or the care received, to formulate advance directives, STD services, and Emergency Services outside Contractor's network pursuant to the federal law, the right to request a State hearing, to have access to their Medical Record, and to disenroll.~~

~~d~~**c.** the Member has the right to be fully informed of his (her) functional status and to request a reassessment by the IDT, to be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (e.g. due to medical reasons or for the Member's welfare or that of other Members).

d. to be provided with information about the organization and its services;

e. to be able to choose a PCP if another PCP is employed by Contractor;

f. to participate in decision making regarding their own health care, including the right to refuse treatment;

g. to voice grievances, either verbally or in writing, about the organization or the care received;

h. to receive oral interpretation services for their language;

i. to formulate advance directives;

j. to have access to sexually transmitted disease services and emergency services outside the Contractor's network pursuant to the federal law;

k. to request a State Medi-Cal Hearing, including information on the circumstances under which an expedited Hearing is possible;

l. to have access to, and where legally appropriate, receive copies of, amend, or correct their Medical Record;

Exhibit A, Attachment 13
Member Services

m. to Disenroll upon request;

n. to receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with Welfare and Institutions Code section 14182, subdivision (b), criteria (12);

o. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

p. to receive information about available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

q. to receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526 (2014); and

r. freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.

2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of Confidential Information to unauthorized persons inside and outside the network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of Confidential Information, unless such consent is not required pursuant to **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ection 51009.

~~3. Contractor shall ensure the Members' confidentiality when accessing Sensitive Services such as STD and HIV testing and counseling.~~

C. Contractor must limit use of restraints as provided in 42 CFR 460.114, as follows:

1) the PACE organization must limit use of restraints to the least restrictive and most effective method available. The term restraint includes either a physical restraint or a chemical restraint.

a. a physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

b. a chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

2) If the interdisciplinary team determines that a restraint is needed to ensure the participant's physical safety or the safety of others, the use must meet the following conditions:

a. be imposed for a defined, limited period of time, based upon the assessed needs of the participant.

b. be imposed in accordance with safe and appropriate restraining techniques.

c. be imposed only when other less restrictive measures have been found to be ineffective to protect the participant or others from harm.

d. be removed or ended at the earliest possible time.

3) The condition of the restrained participant must be continually assessed, monitored, and reevaluated.

Exhibit A, Attachment 13
Member Services

~~C.~~**D.** Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR, ~~Sections~~ 422.128 ~~(2005)~~ and ~~438.6(i)~~.

2. ~~Member Services~~ PACE Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members **or potential members** through sufficient assigned and knowledgeable staff.

B. Contractor shall ensure ~~Member services~~ **PACE** staff are trained on all contractually required Member **or potential member** service functions including policies, procedures, and scope of benefits of this Contract. **Contractor shall provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in his or her continued ability to demonstrate the skills necessary for the performance of the position, as required by 42 CFR 460.66.**

C. Contractor shall develop a training program for each personal care attendant to establish the individual's competency in furnishing personal care services and specialized skills associated with specific care needs of individual members.

~~C.~~**D.** Contractor shall ensure that ~~Member services~~ **PACE** staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with complaint and grievance resolution, access barriers, and disability issues and referral to appropriate clinical services staff.

E. Each member of Contractor's staff that has direct member contact, (employee or contractor) must meet the following conditions, as required by 42 CFR 460.64:

1) Be legally authorized (for example, currently licensed, registered or certified if applicable) to practice in the State in which he or she performs the function or action;

2) Only act within the scope of his or her authority to practice;

3) Have 1 year of experience with a frail or elderly population. If the individual has less than 1 year experience but meets all other requirements in this Provision 2.E, then the individual must receive appropriate training from the PACE organization on working with a frail or elderly population upon hiring;

4) Meet a standardized set of competencies for the specific position description established by the PACE organization and approved by CMS before working independently;

5) Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct member contact.

F. Federally-defined qualifications for physician. In addition to the qualification specified in paragraph (D) of this section, a physician must meet the qualifications and conditions in 42 CFR 410.20.

3. Written Member Information

A. Contractor shall provide to all Members, upon Enrollment in Contractor's plan, the Member Enrollment Agreement/Terms and Conditions and Disclosure Form materials, which constitute a fair disclosure of the provisions of the covered health care services. In the event there are changes in the Member Enrollment Agreement/Terms and Conditions at anytime during the Member's enrollment, Contractor must provide to the Member an updated copy of the information ~~to the Member~~ at least 60 days before any change, and explain the changes to the Member and his or her representative or caregiver in a manner they understand.

B. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level, or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.

Exhibit A, Attachment 13
Member Services

D. **Member information shall include the Member Enrollment Agreement/Terms and Conditions and Disclosure Form materials, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point.**

1) Written Member-information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, provision 10.

2) Written Member information shall be provided in alternative formats (including Braille, large size print, or audio format) and through auxiliary aids and services upon request and in a timely fashion appropriate for the format being requested, and taking into consideration the special needs of Members with disabilities or LEP.

3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all Member information in a specified threshold language or alternative format.

4) Member information in English shall include taglines and information on how to request auxiliary aids and services, including materials in alternative formats, in large print font and all State threshold languages, as identified by DHCS. The taglines shall explain the availability of written Member information translated in that language or oral interpretation to understand the information provided, and the toll-free and TTY/TDD telephone number for these language assistance services.

~~B~~**E.** Contractor shall provide to all Members a Member Enrollment Agreement/Terms and Conditions upon Enrollment that includes the following information:

1) **The plan** ~~N~~name, address, ~~and~~ **toll-free** telephone number **and service area covered by** ~~of Contractor's~~ ~~health~~ **the PACE** plan.

2) A description of all ~~C~~**c**overed **benefits and all available** ~~S~~**s**ervices provided by Contractor, including health education, interpretive services **provided by plan personnel and at the PACE center**

and an explanation of any service ~~limitations and~~ exclusions from coverage **or charges for services** ~~, and identification of all services that are delivered through contracts~~.

3) An explanation of the eligibility criteria and intake process for Enrollment in Contractor's health plan.

4) ~~Process~~ **Procedures** for ~~obtaining~~ **accessing** Covered Services **including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this contract** ~~and referral to Contracted Providers, the address and telephone number of each Service Site~~:

~~The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours including the TDD number.~~
a description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

5) Procedures for requesting a change in PCP, if more than one PCP is employed by Contractor, including requirements for a change in PCP, and reasons for which a request may be denied.

6) ~~Information concerning the availability~~ **The purpose** and value of scheduling an ~~initial health assessment~~ **IHA** appointment.

7) A description of the IDT and responsibilities.

8) Explanation of the Member reassessment process by the health plan and for Member requests for reassessment.

9) The appropriate use of health care services.

10) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers. **This shall include an explanation of the Member's right to interpretive services, at no cost, to assist in receiving after hours services.**

11) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR § 460.100, and that prior

authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

~~11~~**12**) Procedure for obtaining emergency health care **from specified plan providers or from non-plan providers, including** ~~both within and~~ outside Contractor's Service Area.

13) Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.

~~12~~**14**) Procedures for obtaining any transportation services offered by Contractor, and how to obtain such services.

~~13) The causes for which a Member shall be disenrolled from Contractor as stipulated in Exhibit A, Attachment 16, provision 3. Disenrollments.~~

~~14~~**15**) Procedures for filing a ~~G~~**g**rievance~~s~~ ~~and~~ or ~~A~~**a**ppeal~~s~~ **pursuant to 42 CFR 460.122, either** orally ~~and~~ **or** in writing**, or over the phone,** including procedures for appealing decisions regarding Member's coverage, benefits or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the **toll-free telephone number a Member can use to file a grievance or appeal, and the** title, address, and telephone number of the person responsible for processing and resolving ~~G~~**g**rievances and ~~Appeals and person responsible for~~ providing assistance in completing the request. Information regarding the process shall include the **requirements for timeframes to file a grievance or appeal,** and the timelines for the Contractor to acknowledge receipt of ~~G~~**g**rievance**s** ~~and Appeals~~, to resolve ~~G~~**g**rievance~~'~~s ~~and Appeals~~, and to notify the Member of the resolution of ~~G~~**g**rievances ~~and~~ **or** ~~A~~**a**ppeals. Information shall be provided informing the Member that services previously authorized by the Contractor ~~shall~~ **will** continue while the ~~Appeal~~ **grievance** is being resolved.

16) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, provision 3.

~~15~~**17**) Procedures for Disenrollment, including an explanation of the Member's right to ~~d~~**D**isenroll without cause at any time.

~~16~~**18**) An explanation of specific rights to which a Member is entitled.

~~17~~**19**) A description of the Member's premiums and procedures for payment of premiums, including share of cost.

~~18~~**20**) Explanation of a Member's obligation to inform Contractor of a move or more than a 30-day absence from Contractor's Service Area.

~~19~~**21**) Information on the Member's right to the **Medi-Cal** State ~~h~~**Hearing** process**,** **the method for obtaining a Hearing, the timeframe to request a Hearing, and the rules that govern representation in a Hearing**. **Include information on the circumstances under which an expedited State Hearing is possible and information regarding assistance in completing the request,** regardless ~~of whether or not an Appeal~~ **grievance** has been submitted or if the ~~Appeal~~ **grievance** has been resolved, pursuant to **California Code of Regulations ,** ~~T~~**t**itle 22, ~~CCR,~~ Section 53452, when a health care service requested by the Member or provider has been denied, deferred**,** or modified. **Information on State Hearings shall also include information on the timelines which govern a Member's right to a State Hearing, pursuant to Welfare and Institutions Code Section 10951 and** ~~T~~**t**he State Department of Social Services' Public Inquiry and Response Unit toll**-** free telephone number ~~is~~ (**1**-800~~)~~ 952-5253**) to request a State Hearing. Information shall include that services previously authorized by the Contractor will continue while the State Hearing is being resolved if the Member requests a Hearing in the specified timeframe**.

22) Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

23) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHCS.

Exhibit A, Attachment 13
Member Services

~~21~~**24**) Information on how to access State resources for investigation and resolution of Member complaints, including **description of** the DHCS Medi-Cal Managed Care Ombudsman **Program and** toll-free telephone number (1-888-452-8609).

~~22~~**25**) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, ~~S~~**s**ection 7158.2, this notice must be provided **upon enrollment and** annually **thereafter** in the evidence of coverage, **(Member Enrollment Agreement/Terms and Conditions**), health plan newsletter**,** or any other direct communications with Members.

~~23~~**26**) A statement as to whether the ~~plan~~ **Contractor** uses provider financial bonuses or other incentives with its contracting providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's group **or independent practice association**, pursuant to California Health and Safety Code, ~~S~~**s**ection 1367.10.

~~24~~**27**) A notice if the plan uses a drug formulary~~,~~**.** **Pursuant to California Health and Safety Code, Section 1363.01, the notice shall: (1) be in the language that is easily understood and in a format that is easy to understand; (2)** includ**e**~~ing~~ an explanation of what a formulary is**,** how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated~~.~~**;** ~~Pursuant to California Health and Safety Code, Section 1363.01, this notice also must~~ **(3)** indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information~~.~~; **and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a particular medical condition.**

~~25) A notice if a plan uses binding arbitration to settle disputes, pursuant to California Health and Safety Code, Sections 1363 and 1363.1, and the California Code of Civil Procedures, Section 1295.~~

~~26) A statement that the State of California must seek repayment of Medi-Cal benefits from the estate of a deceased Medi-Cal~~

~~beneficiary for services on or after the beneficiary's 55th birthday. For Medi-Cal beneficiaries enrolled (either voluntarily or mandatorily) in a managed care organization, the State must seek recovery of the total premium/capitation payments for the period of time they were enrolled in the managed care organization. Additionally, any other payments made for services provided by non-managed care provider will also be recovered from the estate.~~

28) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of state law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

29) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures; and

30) Any other information determined by DHCS to be essential for the proper receipt of Covered Services.

~~C~~**F**. Contractor shall provide the following information to the Member or Member's family unit either in the form of a cover letter or insert in the above prescribed Member Enrollment Agreement/Terms and Conditions~~.~~**:**

1) each Member's effective date of Enrollment and term of Enrollment~~.~~**; and**

2) the name, telephone number, and ~~Service Site~~ **PACE Center** address of the PCP chosen by or assigned to the Member.

~~D~~**G**. Member Identification Card

Contractor shall issue a Member identification card to each Member ~~upon Enrollment in Contractor's health plan,~~ which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that Emergency Services rendered to the Member by non-contracting providers are reimbursable by **the** Contractor without Prior Authorization by the IDT.

~~E. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member Information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.~~

~~Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed In Exhibit A, Attachment 9, provision 7, Linguistic Services.~~

~~Written Member informing materials shall be provided in alternative formats, (including Braille, large size print, and or audio format) upon request and in a timely fashion appropriate for the format being requested.~~

~~Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.~~

4. Notification ~~to Members About~~ of Changes in Access to Covered Services

A. Contractor shall ~~notify~~ **ensure Medi-Cal** Members **are notified** in writing of any changes in the availability or location of Covered Services ~~being provided by Contractor~~ at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstance, Contractor shall provide notice of the emergency or unforeseeable circumstance to DHCS as soon as possible. The notification must **also** be **presented to and** approved **in writing** by the Department prior to **its** release ~~and need only be sent to those Members affected by the change~~.

5. Primary Care Physician Selection

A. Contractor shall implement and maintain DHCS' approved **policy and** procedures to ensure that each Member has an appropriate and available PCP upon Enrollment in Contractor's plan.

B. Contractor shall ensure that the Member is assigned to a PCP who is an employee of Contractor's plan or otherwise approved by DHCS and ~~Centers for Medicare and Medicaid Services (~~CMS~~)~~ and is responsible for the medical coordination of the Member's health care consistent with federal and State statutes and regulations. In the event the Member becomes dissatisfied with the PCP, Contractor shall allow the Member to

choose another PCP who is employed by Contractor. Contractor shall employ sufficient number of PCPs at all its ~~Service Sites~~ **PACE Centers** to ensure access to appropriate high-quality health care.

C. Contractor shall provide the Member sufficient information (verbal and written) in the appropriate language and reading level about the PCPs available.

Exhibit A, Attachment 14
Member Grievance and Appeals

1. Member Grievance Procedure

A. Contractor shall establish and maintain a **written** procedure for submitting, documenting, processing, and resolving all **medical and nonmedical** Member Grievances, **as required by 42 CFR 460.32(a)(6) and 460.120** in the timeframes outlined in provision 4~~.~~**,** paragraph C, of this Attachment while maintaining confidentiality of the Member's Grievance. Contractor shall submit the procedure to DHCS for review and approval prior to implementation.

B. Contractor shall designate an officer of the plan~~,~~ **(**e.g., chief executive officer, administrative director**,** or medical director**)** to have primary responsibility for maintenance of the procedures, review of their operations, and utilization of any emergent patterns of Grievances to formulate policy changes and procedural improvements in the administration of the plan.

C. **A grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.**

1) Process to resolve grievances. A PACE organization must have a formal written process to evaluate and resolve medical and nonmedical grievances by members, their family members, or representatives.

2) Notification to members. Upon enrollment, and at least annually thereafter, the PACE organization must give a member written information on the grievance process.

3) Minimum requirements. At a minimum, the PACE organization's grievance process must include written procedures for the following:

a. How a member files a grievance.

b. Documentation of a member's grievance.

c. Response to, and resolution of, grievances in a timely manner.

d. Maintenance of confidentiality of a member's grievance.

Exhibit A, Attachment 14
Member Grievance and Appeals

4) Continuing care during grievance process. The PACE organization must continue to furnish all required services to the member during the grievance process.

5) Explaining the grievance process. The PACE organization must discuss with and provide to the member in writing the specific steps, including timeframes for response, that will be taken to resolve the member's grievance.

6) Analyzing grievance information. The PACE organization must maintain, aggregate, and analyze information on grievance proceedings. This information must be used in the PACE organization's internal quality assessment and performance improvement program.

D. A written summary of Grievances including number, type, location, and disposition shall be reviewed periodically by the governing body of the plan and by an officer of the plan or designee. As a part of this review, the reviewers evaluating the summary will determine an emergent pattern of Grievances to be utilized in the formation of policy changes and procedural components in the plan's administration. The execution of each review shall be documented.

E~~D~~. Contractor shall provide a system for addressing any cultural or linguistic requirements related to the processing of Member Grievances prescribed in the contract between the plan and the department.

2. Grievance Systems Oversight

A. Contractor shall maintain in its files copies of all Grievances, the responses to them, and logs recording them; for a period of five years from the date the Grievance was filed.

B. Contractor shall submit a summary of all Grievances in Contractor's quarterly report. The Grievance summary is due 45 days from the date of the end of the reporting quarter.

C. Contractor shall ensure a procedure for the expedited review and disposition of Grievances in the event of a serious or imminent health threat to a Member, in accordance with Health and Safety Code ~~S~~**s**ection~~s~~ 1368**.01** ~~and 1368.02~~**.**

Exhibit A, Attachment 14
Member Grievance and Appeals

3. Member Grievance Assistance

A. Contractor shall provide at least one telephone number for the filing of complaints that shall ensure that Members calling from within the plan's Service Area ~~shall~~ **will** not have to pay long distance charges. Contractor shall provide written notice to Members of the telephone numbers and procedures for filing Grievances.

~~B. Contractor shall ensure that Members are informed of the Grievance processes in writing and provide to Members upon Enrollment into the plan and at least annually thereafter~~.

~~C~~**B**. A person at ~~each service site~~ **the PACE Center** shall promptly furnish Grievance forms and a copy of the Grievance procedures to Members when requested in person, by telephone**,** or by mail.

~~D~~**C**. A person at ~~each Primary Care Service Site and other locations designated by Contractor~~ **the PACE Center** shall provide assistance in the filing of Grievances.

4. Member Grievance Process

A. Each Grievance received in person or by telephone or in writing in accordance with the established procedure shall be recorded in writing, including the date, time, identification of the Member filing the Grievance, identification of the individual recording the Grievance, description of the Grievance, action taken by the health plan, identification of the individual responsible for resolving Grievances, disposition, and date of notification to the Member. Contractor shall submit all medical quality of care Grievances immediately to the medical director or Chief Medical Officer for action.

B. The management or supervisory staff responsible for the services or operations which are the subject of the Grievance shall promptly review the Grievance.

C. Within five days of receipt of a Grievance, Contractor shall provide to the Member who files a Grievance an acknowledgement of receipt of the Grievance and identification of the person or unit, which may be contacted about the Grievance. Contractor shall notify the Member of the disposition of the Grievance or document reasonable efforts to resolve the Grievance normally within 30 days of the date the Grievance was received. When

Exhibit A, Attachment 14
Member Grievance and Appeals

Contractor is unable to distinguish between Grievances and inquiries, they shall be processed as Grievances.

D. Any Member whose Grievance is resolved or unresolved shall have the right to request a State ~~h~~**H**earing. Submission of a Grievance shall not be construed as a waiver of the member's right to request a State ~~h~~**H**earing in accordance with **California Code of Regulations,** ~~T~~**t**itle 22, ~~S~~**s**ections 50951, 51014.1, and 51014.2.

E. In the event resolution is not reached within 30 days, the Member shall be notified in writing by Contractor of the status of the Grievance and shall be provided with an estimated completion date of the resolution. Such notice shall include a statement notifying the Member they may exercise their right to request a State ~~h~~**H**earing in accordance with **California Code of Regulations,** ~~T~~**t**itle 22, ~~S~~**s**ections 50951, 51014.1, and 51014.2.

F. Contractor shall ensure that Members shall continue to receive care during the Grievance process.

G. Contractor shall ensure that there is no discrimination against a Member solely on the grounds that the Member filed a Grievance.

5. Discrimination Grievances

A. Contractor must designate a Section 1557/Civil Rights coordinator responsible for ensuring compliance with non-discrimination requirements and investigating grievances related to non-compliance with federal and state non-discrimination law. This includes language access complaints and complaints alleging failure to make reasonable accommodations under the ADA. Contractor must also adopt a process to ensure the prompt and equitable resolution of these discrimination-related grievances. Contractor shall submit the process to DHCS for review and approval prior to implementation.

B. Contractor's Section 1557/Civil Rights coordinator must be available to:

1) Answer questions and provide appropriate assistance to Contractor staff, Members and Applicants regarding Contractor's state and federal non-discrimination legal obligations;

2) Advise Contractor about non-discrimination best practices and accommodating persons with disabilities; and

3) Investigate and process discrimination grievances, including those alleging violations of the ADA, Section 504, Section 1557, and/or Government Code Section 11135.

C. Contractor shall use a template Notice of Non-Discrimination provided by DHCS to meet the obligation to post its discrimination grievance information as required by Section 1557 of the Affordable Care Act and its implementing regulations (45 CFR 92.8); Sections 14029.91 and 14029.92 of the Welfare and Institutions Code; and All Plan Letter (APL) 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (June 30, 2017), including any superseding All Plan Letter.

D. Within ten calendar days of mailing a discrimination grievance resolution letter to a Member or Eligible Beneficiary, Contractor must forward to the DHCS Office of Civil Rights (OCR) the following information regarding the discrimination grievance:

1. the original complaint;

2. the provider's or other accused party's response to the grievance;

3. contact information for the personnel responsible for the Contractor's response to the grievance;

4. contact information for the Member or Eligible Beneficiary and for the provider or other accused party that is the subject of the grievance;

5. all correspondence with the Member or Eligible Beneficiary regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the Member or Eligible Beneficiary; and

6. any other information that is relevant to the allegation of discrimination;

E. A Member, Eligible Beneficiary, or other interested person may file a discrimination grievance directly with DHCS OCR at any time.

Exhibit A, Attachment 14
Member Grievance and Appeals

Submission of a discrimination grievance to Contractor shall not be construed as a waiver of complainant's other rights regarding the allegedly discriminatory conduct, including the right to submit a grievance alleging discrimination in the Medi-Cal program directly to DHCS OCR or, as applicable, the United States Department of Health and Human Services Office for Civil Rights.

~~5~~6. Member Appeals Process

A. Contractor shall establish and maintain a procedure for submitting, documenting, processing, resolving, and evaluating all Member Appeals in accordance with federal PACE regulations 42 CFR, Sections 460.104(d)(2), 460.122, and 460.124**, 460.32(a)(6), and 460.154(n).**

B. In accordance with federal PACE regulation 42 CFR, Section 460.124, any Member whose Appeal is resolved or unresolved shall have the right to request a State ~~h~~**H**earing. Submission of a~~n~~ **Grievance and or an** Appeal shall not be construed as a waiver of the Member's right to request a State ~~h~~**H**earing in accordance **with California Code of Regulations** ~~T~~**t**itle 22, ~~CCR, S~~**s**ections 50951, 51014.1, 51014.2, and 53261.

~~6~~7. Member Notification of Denial, Deferral or Modification of Requests for Prior Authorization**, and Appeal**

A. Contractor shall notify Members of denial, deferral**,** or modification of request for Prior Authorization, in accordance with Title ~~22, CCR, Sections 51014.1 and 53261 by providing written notification to Members and/or their authorized representatives, regarding the denial, deferral or modification of a request or approval to provide health care services. These notifications must be provided per the timeframes specified in the federal PACE regulations 42 CFR, Sections 460.104(d)(2) and 460.122~~ **42 CFR 460.104 and 460.122.**

~~B. The written notification shall be given by Contractor to the Member and the Member's representative on a standardized form approved by DHCS and shall inform the Member of all the following:~~

~~1) The Member's right to and method for obtaining, a State hearing to contest the denial, deferral or modification action.~~

~~2) The Member's right to represent himself/herself at the State hearing or to be represented by legal counsel, friend or other spokesperson.~~

~~3) The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.~~

~~C. The notice to the Member may inform the Member that the Member may file an Appeal concerning Contractor's action using Contractor's Appeal process prior to or concurrent with the initiation of the State hearing process.~~

B. If a member (or his or her designated representative) believes that the member needs to initiate, eliminate, or continue a particular service, the appropriate members of the interdisciplinary team, as identified by the interdisciplinary team, must conduct a reassessment. The interdisciplinary team member(s) may conduct the reassessment via remote technology when the interdisciplinary team determines that the use of remote technology is appropriate and the service request will likely be deemed necessary to improve or maintain the participant's overall health status and the participant or his or her designated representative agrees to the use of remote technology.

An in-person reassessment must be conducted when participant or his or her designated representative declines the use of remote technology.

C. The PACE organization must have explicit procedures for timely resolution of requests by a member or his or her designated representative to initiate, eliminate, or continue a particular service.

D. Except as provided in paragraph in E of this section, the interdisciplinary team must notify the member or designated representative of its decision to approve or deny the request from the member or designated representative as expeditiously as the member's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request for reassessment.

E. The interdisciplinary team may extend the 72–hour timeframe for notifying the member or designated representative of its decision to approve or deny the request by no more than 5 additional days for either of the following reasons:

Exhibit A, Attachment 14
Member Grievance and Appeals

1) The member or designated representative requests the extension.

2) The team documents its need for additional information and how the delay is in the interest of the member.

F. The PACE organization must explain any denial of a request to the member or the member's designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for the following:

1) Informing the member or designated representative of his or her right to appeal the decision as specified in § 460.122.

2) Describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in § 460.122.

3) Describing the right to, and conditions for, continuation of appealed services through the period of an appeal as specified in § 460.122(e).

4) If the interdisciplinary team fails to provide the member with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the member's request must be automatically processed by the PACE organization as an appeal in accordance with § 460.122.

Exhibit A, Attachment 15
Marketing

1. Marketing

Contractor shall comply with the requirements of 42 CFR 460.82 regarding marketing:

A. Information that a PACE organization must include in its marketing materials.

1) A PACE organization must inform the public about its program and give prospective members the following written information:

a. An adequate description of the PACE organization's Enrollment and Disenrollment policies and requirements.

b. PACE enrollment procedures.

c. Description of benefits and services.

d. Premiums.

e. Other information necessary for prospective members to make an informed decision about enrollment.

2) Marketing information must be free of material inaccuracies, misleading information, or misrepresentations.

B. Approval of marketing information.

1) CMS must approve all marketing information before distribution by the PACE organization, including any revised or updated material.

2) CMS reviews initial marketing information as part of an entity's application for approval as a PACE organization, and approval of the application includes approval of marketing information.

3) Once a PACE Organization is under a PACE program agreement, any revisions to existing marketing information and new information are subject to the following:

a. **Time period for approval. CMS approves or disapproves marketing information within 45 days after CMS receives the information from the organization.**

b. **Deemed approval. Marketing information is deemed approved, and the organization can distribute it, if CMS and the State administering agency do not disapprove the marketing material within the 45–day review period.**

C. Special language requirements

A PACE organization must furnish printed marketing materials to prospective and current members as specified below:

1) **In English and in any other principal languages of the community, as determined by the State in which the PACE organization is located. In the absence of a State standard, a principal language of the community is any language that is spoken in the home by at least 5 percent of the individuals in the PACE organization's service area.**

2) **In Braille, if necessary.**

D. Information on restriction of services

1) **Marketing materials must inform a potential member that he or she must receive all needed health care, including primary care and specialist physician services (other than emergency services), from the PACE organization or from an entity authorized by the PACE organization.**

2) **All marketing materials must state clearly that PACE members may be fully and personally liable for the costs of unauthorized or out–of–PACE program agreement services.**

E. Prohibited marketing practices

A PACE organization must ensure that its employees or its agents do not use prohibited marketing practices including but not limited to those prohibited Marketing practices listed in 42 CFR 460.82(e) and the following:

Exhibit A, Attachment 15
Marketing

1) Discrimination of any kind, except that marketing may be directed to individuals eligible for PACE by reason of their age.

2) Activities that could mislead or confuse potential members, or misrepresent the PACE organization, CMS, or the State administering agency.

3) Gifts or payments to induce enrollment, unless the gifts are of nominal value as defined in CMS guidance, are offered to all potential enrollees without regard to whether they enroll in the PACE program, and are not in the form of cash or other monetary rebates.

4) Marketing by any individual or entity that is directly or indirectly compensated by the PACE organization based on activities or outcomes unless the individual or entity has been appropriately trained on PACE program requirements.

a. PACE organizations are responsible for the activities of contracted individuals or entities who market on their behalf.

b. PACE organizations that choose to use contracted individuals or entities for marketing purposes must develop a method to document training has been provided.

5) Unsolicited door-to-door marketing or other unsolicited means of direct contact, including calling or emailing a potential or current participant without the individual initiating the contact.

~~1.~~**2. Training and Approval of Marketing Representatives**

Contractor shall develop an orientation and training program for Marketing Representatives and Marketing supervisors to ensure that all staff performing Marketing activities or distributing Marketing material are appropriately trained, have passed the DHCS' Medi-Cal Marketing exam and are approved by DHCS to conduct Marketing activities.

A. Contractor is responsible for all Marketing activities conducted on behalf of Contractor. Contractor shall be held liable for any and all violations by any Marketing Representative. Contractor shall ensure, in addition to compliance with the requirements of **California Code of Regulations,** ~~T~~title 22, ~~CCR,~~ ~~S~~**s**ections 53400 through 53458 that:

Exhibit A, Attachment 15
Marketing

1) All Marketing Representatives, including supervisors, have satisfactorily completed Contractor's Marketing orientation and training program and the DHCS Marketing Representative Examination prior to engaging in Marketing activities on behalf of Contractor;~~.~~

2) Marketing Representative shall not provide Marketing services on behalf of more than one Contractor**; and** ~~.~~

3) Marketing Representatives do not engage in Marketing practices that discriminate against an eligible beneficiary because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap**,** or health status.

B. Training Program

1) Contractor shall develop a training and orientation program that shall train staff and prepare Marketing Representatives for the DHCS' Medi-Cal Marketing examination and to perform Marketing activities for Contractor. Contractor shall develop a staff orientation and Marketing Representative's orientation/training manual.

2) Contractor shall provide a memorandum of understanding~~,~~ **(**in the format provided by DHCS**)**~~,~~ that all Marketing Representatives must complete prior to taking the DHCS' Medi-Cal Marketing examination.

3) Contractor shall provide certification by Contractor that the Marketing Representatives have completed the orientation and training program

C. Marketing Presentations

Contractor shall ensure that all Marketing presentations made to eligible Members contain adequate information about Contractor to allow Members to exercise informed judgment in choosing to enroll in Contractor's plan. All Marketing presentations shall fully disclose the availability of and restrictions upon the services provided by Contractor. The information and procedures shall conform to **California Code of Regulations.** ~~T~~title 22, ~~CCR, S~~**s**ection 53404, and as a minimum, specify:

1) Scope, access to, and availability of services;

2) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries;~~.~~

3) An explanation of the nature of the Membership identification which shall authorize the Member to obtain services;~~.~~

4) An explanation that Members shall obtain all covered health care services required and rendered in non-emergency situations, through the plan's providers;~~.~~

5) An explanation that medical services required in an emergency may be obtained at all times from specified plan providers or from non-plan providers, if necessary;~~.~~

6) An explanation that Enrollment is voluntary;~~.~~

7) An explanation that Enrollment is subject to a verification or processing period of 15 to 45 days; and.

8) An explanation that Disenrollment is possible under the conditions specified in Title 22~~,~~ CCR~~,~~ Section 53440 and only after action by DHCS.

~~2~~3. DHCS Approval

A. Contractor shall not conduct Marketing activities without written approval of its Marketing plan from DHCS.

B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped, website, and media scripts, shall be approved in writing by DHCS prior to distribution.

C. Contractor's orientation and training program and changes in the orientation and training program shall be approved in writing by DHCS prior to implementation.

~~D. Contractor shall further comply with federal PACE regulation 42 CFR, Section 460.82(b).~~

~~3. **Marketing Plan**~~

Exhibit A, Attachment 15
Marketing

~~Contractor shall establish, implement, and maintain a Marketing plan approved by DHCS.~~

~~Contractor shall submit a Marketing plan to DHCS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe Contractor's current Marketing procedures, activities, and methods. No new Marketing activity shall occur until the Marketing plan has been approved by DHCS.~~

~~A. The Marketing plan shall have a table of contents section that divides the Marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections or pages, when revised, can be easily identified and replaced with revised submissions.~~

~~B. Contractor's Marketing plan shall contain the following items and exhibits:~~

~~1) Mission Statement or Statement of Purpose for the Marketing plan.~~

~~2) Organizational Chart and Narrative Description~~

~~a. The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.~~

~~b. The description shall explain how Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and reporting relationships.~~

~~3) Marketing Locations~~

~~All sites for proposed Marketing activities such as annual health fairs, and community events, in which Contractor proposes to participate, shall be listed.~~

~~4) Marketing Activities~~

~~All Marketing methods and Marketing activities Contractor expects to use or participate in, shall be described.~~

~~a. Contractor shall provide strict accountability, including documentation of a prospective Member's Marketing~~

~~presentation or a documented telephone log entry showing the request was made.~~

~~b. Include a letter or other document that verifies cooperation or agreement between Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.~~

~~5) Marketing Materials~~

~~Copies of all Marketing materials Contractor shall use for both English and non-English speaking populations shall be included.~~

~~A sample copy of the Marketing identification badge and business card that shall clearly identify Marketing Representatives as employees of Contractor shall be included. The Marketing identification badge shall include:~~

~~a. Photograph of Marketing Representative (wallet size).~~

~~b. Name and job title of Marketing Representative.~~

~~c. Name, phone number and address of Contractor.~~

~~6) Marketing Distribution Methods~~

~~A description of the methods Contractor shall use for distributing Marketing materials.~~

~~7) Monitoring and Reporting Activities~~

~~Written formal measures to monitor performance of Marketing Representatives to ensure Marketing integrity pursuant to W&I Code, Section 14408(c).~~

~~8) Miscellaneous~~

~~All other information requested by DHCS to assess Contractor's Marketing program.~~

4. Signed Certifications

Exhibit A, Attachment 15
Marketing

A. Contractor shall provide a signed certification that Contractor shall abide by all Medi-Cal Marketing requirements and conditions.

B. Contractor shall provide a signed certification that all Marketing staff are employees of the Contractor.

5. **Medi-Cal Marketing Representative Reporting Requirements**

Contractor shall submit to DHCS a status of Marketing Representatives every three months.

6. **Mass Marketing Mailers**

Contractor may request mass market mailings of their Marketing material to Medi-Cal beneficiaries by using the mailing services provided by DHCS. Contractor shall notify DHCS 45 days in advance of the mailer being sent. Contractor shall be invoiced and all departmental costs associated to the mass mailing services shall be reimbursed to DHCS within 30 days of receipt of invoice.

~~7.~~ ~~**Prohibited Marketing Practices**~~

~~Contractor must ensure that its employees or its subcontractors do not use prohibited Marketing practices, and which include the following:~~

~~A. Contractor shall not engage in door to door or cold call Marketing for the purpose of enrolling Members or Potential Enrollees or for any other purpose.~~

~~B. Contractor shall not conduct Marketing presentations at Primary Care Sites.~~

~~C. Contractor shall not misrepresent themselves, Medicare or the Medi-Cal program through false advertising, false statements or activities that involve gifts or payments.~~

~~D. Contractor shall not Subcontract outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.~~

~~E. Contractor shall be held responsible for any violations. Violations of this section shall include, but are not limited to, false or misleading claims, inferences or representations that:~~

Exhibit A, Attachment 15
Marketing

~~1) Marketing Representatives are employees or representatives of the State, county, or anyone other than the plan or Marketing organization by which they are reimbursed.~~

~~2) The plan is recommended or endorsed by any State agency or county agency or any other organization, which has not certified its endorsement of the plan in writing.~~

~~3) The State or county recommends that a Medi-Cal Member enroll in the plan.~~

~~4) Medi-Cal Member shall lose benefits under the Medi-Cal program or any other health or welfare benefits to which he/she is legally entitled if the Member does not enroll in a plan.~~

Exhibit A, Attachment 16
Enrollments and Disenrollments

1. Contractor shall comply with the Member Enrollment and Disenrollment requirements set forth in 42 CFR 460.150 through 460.172.

~~1~~2. Submittal of Enrollment and Disenrollment Files

Contractor shall submit Enrollments and Disenrollments in ~~the following manner:~~

~~Submit electronic Enrollments and Disenrollments to the DHCS' Information Technology Services Division, Data Guidance, via E-mail to hcptech@dhcs.ca.gov, and your designated contract manager, prior to the Managed Care Plan FAME cutoff processing schedule or any time after the first of the month~~ **accordance with PACE Policy Letter 20-01 and updates thereto**.

~~2~~3. Enrollment

Contractor shall accept as Members Medi-Cal beneficiaries voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, provision 35. ~~Eligible Beneficiaries.~~

A. ~~Enrollment:~~ - General

Eligible Medi-Cal beneficiaries residing within the approved service area of Contractor, as defined in Exhibit E, Attachment I, provision 92~~.~~**,** may voluntarily apply for Enrollment under this Contract at any time during the term of this Contract. **Beneficiaries meeting the eligibility requirements of 42 CFR 460.150** ~~Eligible beneficiaries~~ shall be accepted by Contractor in the order in which they apply and without regard to ~~physical~~ **health status** or mental condition **disability**, age, ~~sex~~ **gender**, race, religion, creed, color, national origin, marital status, sexual orientation**,** or ancestry.

Eligibility to enroll in a PACE program is governed by 42 CFR 460.150, which states:

1) General rule. To enroll in a PACE program, an individual must meet eligibility requirements specified in this section. To continue to be eligible for PACE, an individual must meet the annual recertification requirements specified in Section 460.160.

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

a. be 55 years of age or older;

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

c. reside in the service area of the PACE organization; and

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

3) Other eligibility requirements.

a. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety

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

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

(1) entitled to Medicare Part A;

(2) enrolled under Medicare Part B; and/or

(3) eligible for Medicaid.

To be eligible for payment under this Contract, the individual must be eligible for Medi-Cal.

Exhibit A, Attachment 16
Enrollments and Disenrollments

The enrollment process to be followed by Contractor is set forth in 42 CFR 460.152. The enrollment agreement must comply with the requirements of 42 CFR 460.154. Other enrollment procedures set forth in 42 CFR 460.156.

B. Coverage

1) A member's enrollment in Contractor's PACE plan is effective on the first day of the calendar month following the date Contractor receives the signed enrollment agreement, as provided by 42 CFR 460.158. The member's continuation of enrollment is governed by the requirements of 42 CFR 160. The term of ~~Membership~~ **enrollment** shall continue indefinitely unless this Contract expires, is terminated or the Member is disenrolled under the conditions described in provision ~~3~~**4** ~~of this Attachment~~.

2) Enrollment is contingent ~~upon completion of a designation form in compliance with requirements of W&I Code, Section 14088(c) and~~ continued financial eligibility **for Medi-Cal,** and initial eligibility for long-term care as determined by DHCS.

3) The member's eligibility for long-term care must be reevaluated by DHCS at least annually, unless DHCS determines there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the member. A member may be deemed to continue to be eligible for the PACE program notwithstanding a determination that the individual no longer nursing facility level of care if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period. (42 USC 1395eee(c)(3) and (4).) As provided by 42 CFR 460.160:

a. DHCS may permanently waive the annual recertification requirement for a member if it determines that there is no reasonable expectation of improvement or significant change in the member's condition because of the

severity of a chronic condition or the degree of impairment of functional capacity.

b. Contractor must retain in the member's medical record the documentation of the reason for waiving the annual recertification requirement.

c. If DHCS determines that a PACE member no longer meets the Medi-Cal nursing facility level of care requirements, the member may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the member reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months.

DHCS has establish criteria to use in making the determination of "deemed continued eligibility." DHCS, in consultation with Contractor, makes a determination of deemed continued eligibility based on a review of the member's medical record and plan of care. These criteria must be applied in reviewing the member's medical record and plan of care. In accordance with PACE Policy Letter 02-14 and updates thereto.

C. Information to Prospective Members

Contractors must i Inform each Medi-Cal Member signing an Enrollment ~~application~~ **Agreement**, in writing, of the following:

1) ~~There is a 15 to 45-day processing period between the date the Enrollment application is received by Contractor and the date Contractor receives written notice from the DHCS that the Member has been enrolled.~~ **Member enrollment will be effective on the first day of the month following Contractor submission of the Enrollment Agreement to DHCS.**

~~2) Official Enrollment in Contractor's plan is not effective until processing is completed by DHCS.~~

~~3~~**2**) ~~A Member may D~~isenroll upon request, without having to provide a reason for the request, at any time after the

~~effective date of Enrollment.~~ **At any time, a member may request to disenroll from the PACE Organization, without having to provide a reason for the request. The disenrollment will be effective the first day of the month following the date the PACE Organization receives the request.**

~~3~~4. Disenrollment

~~Disenrollment may take place under the following conditions subject to approval by DHCS in accordance with the provisions of Title 22, CCR, Section 53440~~

As required by 42 CFR 460.172, Contractor must have a procedure in place to document the reasons for all voluntary and involuntary disenrollments. Contractor must make that documentation available for review by CMS and DHCS. Contractor must use the information on voluntary disenrollments in the PACE organization's internal quality improvement program.

A. Voluntary Disenrollment

1) A member's voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the member's notice of voluntary disenrollment.

2) A PACE member may voluntarily disenroll from the program without cause at any time.

3) The Contractor must ensure that its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.

B. Involuntary Disenrollment

A member's involuntary disenrollment occurs after the Contractor meets the requirements set forth in this section and is effective on the first day of the next month that begins 30 days after the day the PACE organization sends notice of the disenrollment to the member.

As provided in 42 CFR 460.164, Contractor may involuntarily disenroll a member for any of the following reasons:

Exhibit A, Attachment 16
Enrollments and Disenrollments

1) The member, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any premium due to the Contractor;

2) The member, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medi-Cal spenddown liability or any amount due under the post-eligibility treatment of income process, as permitted under §§460.182 and 460.184;

3) The member, or the member's caregiver engages in disruptive or threatening behavior, and exhibits either of the following:

   a. A member whose behavior jeopardizes his or her health or safety, or the safety of other; or

   b. A member with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

   c. A member's caregiver who engages in disruptive or threatening behavior exhibits behavior that jeopardizes the member's health or safety, or the safety of the caregiver or others.

   The Conractor may not disenroll a member on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

4) The member moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the Contractor agrees to a longer absence due to extenuating circumstances;

5) The member is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible;

Exhibit A, Attachment 16
Enrollments and Disenrollments

6) The Contractor's agreement with CMS and DHCS is not renewed or is terminated; and

7) The Contractor is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

~~A. Disenrollment of a Member is mandatory when:~~

~~1) The member requests Disenrollment.~~

~~2) The Member's eligibility as a Medi-Cal beneficiary is ended, including the death of the Member or eligibility for Enrollment in the plan is terminated.~~

~~3) There is a change of a Member's place of residence to outside Contractor's Service Area or the Member is out of the area for more than 30 consecutive days, unless Contractor agrees to a longer absence due to extenuating circumstances.~~

~~4) The Member is determined to no longer meet the State Medicaid nursing Facility level of care requirements and is not deemed eligible.~~

~~5) Member is repeatedly verbally abusive to Contracted providers, ancillary or administrative staff, subcontractor staff or to other plan Members.~~

~~6) Member physically assaults a Contracted provider or staff person, subcontractor staff person or other Member or threatens another individual with a weapon on Contractor premises or subcontractor's premises. In this instance, Contractor or subcontractor shall file a police or security agency report and file charges against the Member.~~

~~7) Member who engages in disruptive or threatening behavior and exhibits either of the following:~~

~~a. Jeopardizes his (her) own health or safety or the safety of others; or~~

~~b. Member with a decision-making capacity who consistently refuses to comply with his (her) individual plan of care or the terms of Contractor's Enrollment Agreement.~~

Exhibit A, Attachment 16
Enrollments and Disenrollments

~~8) Member fails to pay, or make satisfactory arrangements to pay, any premium due Contractor after a 30-day grace period.~~

~~9) Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan Membership card to receive services from Contractor.~~

~~10) Contract with the State is not renewed or terminated.~~

As required by 42 CFR 460.166, in disenrolling a member, Contractor must use the most expedient process allowed as set forth in this Contract, coordinate the disenrollment date between Medicare and Medicaid (for a member who is eligible for both Medicare and Medicaid), and give reasonable advance notice to the member. Until the date enrollment is terminated, members must continue to use PACE organization. Contractor must continue to furnish all needed services until the date of disenrollment.

~~B. The problem resolution attempted prior to a Contractor-initiated Disenrollment described in paragraph B must be documented by Contractor~~. **Contractor shall establish a** formal procedure for Contractor-initiated **involuntary** Disenrollments ~~shall be established by Contractor and~~ **that meets the approval of DHCS** ~~approved by DHCS~~. As part of the procedure, the Member shall be notified in writing by Contractor of the intent to ~~d~~**D**isenroll the Member for cause and allowed a period of no less than 20 days to respond to the proposed action.

~~1)~~**C** Contractor must submit a written request for Disenrollment and the documentation supporting the request to DHCS for approval. The supporting documentation must establish **the reason for proposing to involuntary disenroll the member and all efforts to remedy the situation.** ~~the pattern of behavior and Contractor's efforts to resolve the problem.~~ DHCS shall review the request and render a decision in writing within **ten** ~~(10)~~ State working days of receipt of a Contractor request and necessary documentation. If **Contractor-initiated** ~~the~~ request **for Disenrollment** is approved **by DHCS**, DHCS shall process the Disenrollment. Contractor shall be notified by DHCS of the decision, and if the request is granted, shall be notified of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause **(involuntary disenrollment)** if DHCS grants Contractor-initiated request for Disenrollment.

Exhibit A, Attachment 16
Enrollments and Disenrollments

~~2)~~ ~~Contractor shall continue to provide Covered Services to the Member until the effective date of the Disenrollment.~~

~~E~~**D.** Membership shall cease **no later than** ~~at~~ midnight on the last day of the **first** calendar month **after** ~~in which~~ the ~~Member's~~ **Contactor's** Disenrollment request **and all required supporting documentation** ~~is approved~~ **are received** by DHCS. On the first day **after Enrollment ceases,** ~~of the month following the approval of the Disenrollment request,~~ Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor ~~agrees in turn to~~ **shall** return to DHCS any Capitation payment forwarded to Contractor for persons not enrolled under this Contract.

E. In the case of an individual whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), Contractor shall provide assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers, and take action in compliance 42 CFR 460.168 to facilitate the individual's reinstatement in other Medicare and Medicaid programs. Contractor may reinstate a previously enrolled member.

Exhibit A, Attachment 17
Reporting Requirements

1. Contractor shall furnish the following reports and information to the DHCS and/or ~~LTCD~~ **ISCD** (unless specifically exempted from reporting **by DHCS** ~~pursuant to W&I Code, Section 14308~~):

   A. On an annual basis:

      1) The ~~F~~**f**inancial audit report ~~required by W&I Code, Section 14459~~. **in compliance with this Exhibit A, Attachment 2, provision 2.** This report shall be submitted to the DHCS no later than ~~120~~ **180** calendar days after the close of Contractor's fiscal year~~.~~**;**

      2) A disclosure statement in compliance with this Exhibit A, Attachment 1, provision 2A~~.~~**;**

      3) Facility aggregate report for ~~Service Sites~~ **PACE Centers** and Contracted Providers~~.~~**;**

      4) Enrollment Agreement: Terms and Conditions update~~.~~**;**

      5) Results of Member satisfaction surveys~~.~~**;**

      6) Contractor shall submit an updated Contracted Provider Directory, which**,** at a minimum**,** contains the following information:

         a. ~~H~~**h**eaders to indicate city or region names (in alphabetical order)**;**

         b. ~~S~~**s**pecialty (e.g. Optometry)**;**

         c. ~~P~~**p**rovider's name (last, first-listed alphabetically)**;**
            Street address
            City including zip codes
            Telephone number including area code

         d. ~~L~~**l**anguages (other than English) spoken at the provider site**; and**

         e. ~~M~~**m**edical Group/Institutional/Specialty name (e.g. University of California)

      7) Summary of all Quality Assurance activities~~.~~**;**

Exhibit A, Attachment 17
Reporting Requirements

8) Progress report of major events, program applications and developments, research activities and administration. The report shall include, but not be limited to, Member demographic characteristics; medical diagnosis by disease categories**,** and physical, cognitive**,** and functional status; member/program census, service cost and utilization statistics, difficulties or special problems, pertinent facts**,** or interim findings. Submit copy of progress report to CMS if different ~~than~~ **from** above~~.~~**;**

9) Financial reports relevant to affiliates as specified in **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53330~~.~~**;**

10) Copies of any financial reports submitted to other public or private organizations as specified in **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ection 53324 **,subdivision** (d)~~.~~**;**

11) Additions and deletions to Marketing Representative staff~~.~~**;**

12) Summary of Member Grievances, Appeals, and Unusual Incidents**;**

13) Summary of Provider Grievances**; and**

14) Listing of all Contractor's Subcontract providers which includes a listing of new ~~s~~**S**ubcontractors and those contracts terminated during the quarter

B. On a quarterly basis (within ~~45~~ **forty-five** calendar days of the end of each quarter under this Contract):

1) Utilization and statistical data in compliance with **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53314 in accordance with the reporting format approved by DHCS.

2) Financial reports required by **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53324 **subdivision** (c), unless waived in writing by the Department.

2. Other reports to be submitted to the DHCS include:

A. information requested by the DHCS to conduct medical, financial, Contract monitoring, and review activities in accordance with W&~~I~~**elfare and Institutions** Code, ~~S~~**s**ections 14456 and 14457~~.~~**;**

Exhibit A, Attachment 17
Reporting Requirements

B. results of Quality of Care studies and/or progress reports shall be submitted every six months~~.~~**;**

C. new and revised Contractor's policies and procedures ~~on an ongoing basis.~~ **upon the request of DHCS;**

D. notification of possible Third-Party Tort Liability situations, including Workers' Compensation situations. This information shall be submitted within ~~10~~ **ten** calendar days of discovery~~.~~**;**

E. names of Contractor's employees who are subject to the requirements of **California Code of Regulations** ~~T~~**t**itle 22~~,~~ CCR~~,~~ ~~S~~**s**ection 53600 **,subdivision** (f). This information shall be reported to the Department within ~~10~~ **ten** days of the employment date~~.~~**;**

F. information necessary for evaluation of compliance with **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53402~~.~~**;**

G. a completed ~~D~~**d**isclosure ~~S~~**s**tatement at the time the Contract is executed, annually with Contractor's Certified Public Accountant audit and financial statement, and within ~~35~~ **thirty-five** days of a written request by DHCS or DHHS of any change in previously submitted information~~.~~**;**

H. contractor shall notify DHCS within ~~10~~ **ten** days of any changes in key personnel pursuant to PACE Policy Letter 06-03~~.~~**;**

I. contractor shall notify DHCS of Disenrollments that have occurred after MEDS/FAME processing cut-off date for hard copy submissions due to deaths and/or out of Service Area~~.~~**; and**

J. contractor shall submit to DHCS a monthly report listing all active Members as of the first day of the month including pertinent Medi-Cal, Medically Needy Only/Share of Cost and Medicare eligibility information for each Member. The reports shall also include a listing of all new (additions) and terminating (deletions) Member activity for the month, and the reason for any listed terminations.

K. Submittal of Inpatient Days Information

Upon DHCS' written request, Contractor shall report hospital inpatient days to DHCS as required by Welfare and Institutions Code, Section 14105.985(b)(2) for the time period and in the form

Exhibit A, Attachment 17
Reporting Requirements

and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor shall submit additional reports to DHCS, as requested, for the administration of the disproportionate share hospital program.

Exhibit B
Budget Detail and Payment Provisions

Budget Detail and Payment Provisions

Exhibit B
Budget Detail and Payment Provisions

1. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this ~~Agreement~~ **Contract**, and Contractor shall not be obligated to perform any provisions of this ~~Agreement~~ **Contract**. Further, should funding for any fiscal year be reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to:

1) Cancel this ~~Agreement~~ **Contract** with no liability occurring to the State and no further obligation by Contractor to perform, or

2) Offer a~~n agreement~~ **contract** amendment to Contractor to reflect the reduced amount.

B. All payments and rate adjustments are subject to appropriations of Medi-Cal funds by the Legislature and may require Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

2. Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

~~2~~3. Contractor Risk In Providing Services

Contractor shall assume the total risk of providing the Covered Services on the basis of the periodic Capitation payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by Contractor after having fulfilled obligations under this Contract shall be retained by Contractor.

~~3~~4. Capitation Rates

A. The State shall remit to Contractor a Capitation payment ~~for each Member,~~ for each month **for each Medi-Cal Member that** ~~in which such Member is eligible for Medi-Cal benefits and~~ appears on the approved list of Members supplied to Contractor by DHCS. **The capitation rate shall be the amount specified in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement. The payment period for health care services shall**

commence on the first day of operations, as determined by DHCS. Capitation payments shall be made in accordance with the schedule of capitation payment rate ~~Contractor shall be paid Capitation~~ at the end of each month. **For aid codes see DEFINITION, Eligible Beneficiary.**

~~A~~**B**. For Share of Cost Members, payment shall be made at the end of the month following certification by Contractor that the Member's Share of Cost has been collected and cleared through the DHCS' Point of Service device prior to the first calendar date listed on DHCS' Managed Care Plan FAME Cut-Off/Processing Schedule.

~~B~~**C**. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for Contractor, then the split aid code shall automatically be included in the same aid code rate group as the original aid code covered under this Contract. Contractor agrees to continue providing Covered Services to the Members at the monthly Capitation Rate specified for the original aid code. DHCS shall confirm all aid codes splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

~~C~~**D**. Capitation payments shall be made in accordance with the schedule of Capitation Rates set forth in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement~~, and Exhibit B, Attachment 2, Capitation Rate Worksheet(s)~~.

4**5**. Capitation Rates Constitute Payment In Full

~~The Capitation payment constitutes payment in full by the DHCS on behalf of a Member for all Covered Services required by such Member, subject to the provisions of Exhibit E, Attachment 3, provision 8. Risk Limitation, and for all administrative costs incurred by Contractor in providing or arranging for such services, but does not include payment for the recoupment of current or previous losses incurred by Contractor. The basis for the determination of the Capitation payment rates is outlined in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement.~~

Capitation rates for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. DHCS is not responsible for making payments for recoupment of losses.

Exhibit B
Budget Detail and Payment Provisions

~~5~~6. Determination Of Rates

A. DHCS shall determine the capitation rates on a yearly basis. DHCS shall make an annual redetermination of rates for each rate year defined as the 12-month period from January 1 through December 31. DHCS shall attempt to negotiate rates in good faith for each rate year in accordance with Title 42, CFR, Section 460.182. DHCS reserves the right to establish rates on an actuarial basis for each rate year which it shall do in accordance with Welfare and Institutions Code Section 14301.1(n), and Title 42, CFR, Sections 438.6 and 460.182. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Once DHCS establishes rates on an actuarial**ly sound** basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through ~~the~~ **an** amendment ~~process~~ **to this contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 3. Amendment Process.** Change orders shall be utilized in the event that DHCS and the Contractor cannot reach an agreement. Negotiations may still continue and the Contractor may initiate a dispute in accordance with Exhibit E, Attachment 2, Provision 18, Disputes and retains the right to terminate the contract is unable to reach agreement with DHCS. A change order to this Contract shall be in accordance with W&I Code Section 14301(c) and the provision of Exhibit E, Attachment 2, provision 4, Change Requirements, subject to the following:

1) The amendment or change order shall be effective as of January 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment or change order may not be processed in time to permit payment of new rates commencing January 1, the payment to Contractor shall continue at the rates stated in an R Letter sent to the Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon final approval of the amendment or change order providing for the rate change, DHCS

shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the amendment or change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

   a. Any underpayment by the State shall be paid to Contractor within 30 **calendar** days after final approval of the new rates.

   b. Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

4) If **mutual agreement between DHCS and** the Contractor **cannot be attained on** ~~does not accept the c~~**C**apitation rates for subsequent rate years ~~resulting from a rate change pursuant to this Contract, then the~~ Contractor shall retain the right to terminate the Contract. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, provision 14. ~~Termination for Cause and Other Terminations.~~ DHCS shall pay the ~~c~~**C**apitation rates last offered for that rate period until the Contract is terminated.

5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or provision 7 below at the earliest possible time prior to implementation of the new rate.

~~6~~7. Redetermination ~~O~~of Rates: Obligation Changes

The Capitation Rates may be adjusted during the rate year to provide for a change in obligations ~~which~~ **that** results in an increase or decrease **of more than one percent of** ~~in~~ costs ~~(as defined in~~ **California Code of Regulations title 22**

Section 53869) to **the** Contractor~~, in accordance with the provisions of W&I Code, Section 14301(c) and regulations adopted thereunder~~. Any ~~such~~ adjustment**s** shall be effectuated through an amendment ~~or change order~~ to this Contract ~~in accordance with the provisions of Exhibit E, Attachment 2, provision 3. Amendment Process,~~ subject to the following provisions:

A. The amendment ~~or change order~~ shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.~~;~~ **; and**

B. In the event DHCS is unable to process the amendment ~~or change order~~ in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. ~~Such c~~**C**ontinued payment shall constitute interim payment only. Upon final approval of the amendment ~~or change order~~ providing for ~~such~~ **the** change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

~~C.~~ ~~Change orders shall be utilized in the event that DHCS and the Contractor cannot reach an agreement. Negotiations may still continue and the Contractor may also initiate a dispute in accordance with Exhibit E, Attachment 2, Provision 18, Disputes and retains the right to terminate the contract if unable to reach agreement with DHCS. A change order to this Contract shall be in accordance with W&I Code Section 14301(c) and the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements~~.

~~D~~**C**. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, ~~P~~**p**rovision 14, ~~Termination for Cause and Other Terminations~~, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

~~7~~8. Reinsurance

Contractor may obtain Reinsurance (stop loss coverage) ~~or may self-insure upon approval by DHCS~~ to ensure maintenance of adequate capital by Contractor, for the cost of providing Covered Services under this Contract. Pursuant to **California Code of Regulation** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ection 53252 (a)(2)(A) &(B), Reinsurance shall not limit Contractor's liability below $5,000 per Member for any

12-month period as specified by DHCS, and Contractor may obtain Reinsurance for the total cost of services provided to Members by non-Contractor emergency service providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

~~8~~9. Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for care for illness of or injury to Members, which results from or is greatly aggravated by, a catastrophic occurrence or disaster. Contractor shall return a prorated amount of the Capitation payment following the DHCS Director's invocation of the catastrophic coverage limitation. The amount returned ~~shall~~ **will** be determined by dividing the total Capitation payment by the number of days in the month. The amount ~~shall~~ **will** be returned to DHCS for each day in the month after the Director has invoked the catastrophic coverage limitation clause.

~~9~~10. ~~This provision intentionally left blank.~~ Financial Performance Guarantee

Contractor shall provide satisfactory evidence of, and maintain Financial Performance Guarantee in, an amount equal to at least one month's capitation payment, in a manner specified by DHCS. At the Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of this Contract unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to the Financial Performance Guarantee, shall be as specified in California Code of Regulations title 22 section 53865.

~~10~~11. Recovery Of Capitation Payments

DHCS shall have the right to recover **from Contractor** amounts paid to Contractor in the following circumstances as specified:

A. If DHCS determines that a Member has either been improperly enrolled, due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area or pursuant to **California Code of Regulations** ~~T~~title 22, ~~S~~section 53440(a)(2) or should have been disenrolled with an effective date in a prior month. DHCS may recover the Capitation payments made to Contractor for the Member for the months in

question**. To the extent permitted by law**, Contractor may seek to recover any payments made to providers for Covered Services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question ~~shall~~ **may** be paid by the DHCS~~'~~ fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHCS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision 18. Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHCS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, provision 4.

B. As a result of Contractor's failure to perform their contractual responsibilities to comply with mandatory federal Medicaid requirements, the ~~Federal Department of Health and Human Services~~ ~~(~~DHHS~~)~~ may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. DHCS may recover the amounts disallowed by DHHS by an offset to the Capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six ~~(~~6~~)~~ months.

~~C. DHCS determines that an improper or erroneous AIDS claim payment has been made to Contractor. Improper or erroneous AIDS claim payments shall be recovered by the DHCS in conformance with this Exhibit.~~

~~D~~**C**. ~~The~~ DHCS determines that any other erroneous or improper payment not mentioned above has been made to Contractor. DHCS may recover the amounts determined by an offset to the Capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six ~~(~~6~~)~~ months. At least 30 days prior to seeking any such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

Exhibit B
Budget Detail and Payment Provisions

~~11~~12. Requirements for Payments of Retroactive Capitation (Retrocapitation) for Eligible Members

A. Contractor may submit to DHCS a request for payment of retroactive Capitation payments for Members that continued to receive all services offered by the PACE plan, but for whom Capitation payments were not made by DHCS due to the Member's eligibility being placed on hold status. Requests for retrocapitation payments shall be made immediately upon clearance of the Member's eligibility status or no later than 30 days after the Member's eligibility status has been restored. Retrocapitation payments are subject to the discretion of the Department, and will be made only if all of the following conditions have been met:

1) Contractor's request for payment of retrocapitation must provide adequate and sufficient verifiable documentation for each request, including all information requested by DHCS;

2) Enrollment in the PACE plan has been verified through MEDS for each month retrocapitation payments are being requested;

3) During the period for which Contractor is requesting a retrocapitation payment, the Contractor has continued to satisfactorily demonstrate that the plan reconciles and reports eligibility for all Members on a monthly basis using the FAME report as well as supplemental reports submitted by ~~the~~ Medi-Cal Managed Care ~~Division~~;

4) The request for retrocapitation payments for ~~participants~~ **members** with a previous unmet share of cost has been reconciled and submitted on a monthly basis In accordance with Exhibit B, ~~P~~ **p**rovision 3, ~~Capitation Rates~~; and

5) Contractor is, in the ~~Department's~~ **DHCS'** determination, in substantial compliance with all contractual requirements at the time a request for retrocapitation is made.

B. Retrocapitation payment requests shall be made within 30 days from the end of the month during which the Member for whom retrocapitation payments are being requested has had their eligibility status removed from hold status. Under no circumstances will the ~~Department~~ **DHCS** consider retrocapitation payment requests more than six months from the time the Member's eligibility status has been restored.

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Exhibit B
Budget Detail and Payment Provisions

C. All decisions by DHCS with respect to approval or denial of a request for retrocapltatlon shall be final.

D. Documentation ~~that may be~~ required to be submitted by the PACE plan includes, but is not limited to the following:

1) Medi-Cal Eligibility Verification from Point of Service (POS) device and/or Notice of Action issued from the County for the requested month(s) of retrocapitation;

2) HCP FAME Record displaying the Member's eligibility and HCP status, with the months for which retrocapitation is requested highlighted;

3) All Batch Transmittals, Enrollment Form and Agreement submitted to DHCS for processing, including initial enrollment documents and resubmitted documents;

4) Letter from the County in which the Member resides providing verification of county residence and date of residency; and

5) Monthly share of cost listing for the requested month(s) of retrocapitation, with the Member's name and share of cost amount highlighted.

E. For the purpose of processing retrocapitation requests, DHCS shall have available and shall provide to Contractor upon request, a form for Contractor to use when submitting to DHCS all required Member information for DHCS to review in support of Contractor's request for retrocapitation.

PACE Plan Name
Contract Number

Exhibit B, Attachment 1
Rate of Medi-Cal Reimbursement

Federal regulation (42 CFR 460.182) requires that the state makes monthly capitation payments to PACE organization for Medi-Cal participants which are less than the amount that would otherwise have been paid (AWOP) under the State plan if those participants were not enrolled in the PACE program.

Effective January 1, 2018, the capitation rates shall be compliant with State Plan Amendment 18-005.

[County] – [Plan Code] – [HCP Number]

Commencing [DATE]		Full Duals	Non-Duals
Groups	Aid Codes	Rate	Rate
Family	01, 02, 0A, 3E, 3L, 3M, 3N, 3U, 3W, M3		
SPD	20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H		
Adult	53, 81		
Adult Expansion	M1, 7U, L1, L6		

Exhibit E, Attachment 1
Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms shall govern the construction of this Contract:

Action means a termination, suspension, or reduction (which includes denial of a service based on OGC interpretation of 42 CFR 431) of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Actual Non-Service Expenditures means Contractor's actual amounts incurred for non-service expenditures, including both administrative and care management costs, for Full Benefit Dual Eligible Members and excludes costs incurred by Contractor prior to the start of this Risk Corridor. Any reinsurance costs reflected will be net reinsurance costs.

Actual Service Expenditures means Contractor's actual amount paid for providing services to Full Benefit Dual Eligible Members priced at Contractor fee level, and shall comprise of all provider payments for services to this population, including risk-sharing arrangements or sub-capitation payments.

Adjusted Non-Service Expenditures means Contractor's Actual Non-Service Expenditures, adjusted to reflect the exclusion of costs greater than 125 percent of the non-medical cost per Member per month across all participating Contractors and including any consideration given to Contractor for any significant, non-typical membership mixes that may cause this exclusion to come into effect as well as the exclusion of reinsurance costs which is the net of reinsurance premiums; and adjustments resulting from DHCS' review of Contractor's non-service expenditures to address any inappropriate or excessive non-service expenditures, including executive compensation and stop loss expenditures.

Adjusted Service Expenditures means Contractor's Actual Service Expenditures adjusted to reflect the following reductions from any recoveries of other payers outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Member contributions to care; and adjustments resulting from DHCS' review of Contractor reimbursement methodologies and levels to address any excessive pricing.

Exhibit E, Attachment 1
Definitions

~~1.~~ **Administrative Costs** means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in California Code of Regulations, title 22, Section 78007.

Adult Day Health Care (ADHC) Center means a facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department of Public Health pursuant to California Code of Regulations, title 22, section 54105.

Advance Directive: a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

~~2.~~ **Affiliate** means an organization or person that directly or indirectly through one or more intermediaries' controls or is controlled by or is under control with Contractor and that provides services to or receives services from, Contractor.

~~3. **AIDS Beneficiary** means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.~~

~~4.~~ **Allied Health Personnel** means specially trained, licensed or credentialed health workers other than Physicians, podiatrists, and Nurses.

Allowed Medical Expenses means Contractor's actual expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to providers,

and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the MLR calculation, designated medical expense amounts included in the capitation rates that Contractor is required to pay providers, such as for intergovernmental transfers and Hospital Quality Assurance Fees, are excluded.

B. Global sub-capitation payments made by Contractor, where entire medical expenses are shifted to another entity, possibly net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS of the net capitation payments for consideration within Allowed Medical Expenses.

C. Payments by Contractor to related party providers shall not exceed the rate paid by Contractor for the same services to unrelated parties within the same county. Related parties are defined by GAAP.

~~5.~~ **Ambulatory Care** means the type of health services that are provided on an outpatient basis.

~~6.~~ **Appeal** means a Member's action taken with respect to the PACE organization's noncoverage of, **modification of,** or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.

~~7.~~ **Applicant** means any Member, as defined in this Attachment, provision 59, who has applied for Membership in Contractor's plan.

~~8.~~ **At-Risk Service** means any identified Covered Service, as defined in this Attachment, provision 26A which Contractor agrees to accept responsibility to provide or arrange for in exchange for the Capitation payment.

~~9~~. **Beneficiary Identification Card (BIC)** means a permanent plastic card issued by the State to Medi-Cal recipients of entitlement programs which is used by Contractors to verify Medi-Cal eligibility.

Capitated Revenues means the amount of the PACE Capitation payments/revenues paid to Contractor by DHCS for all services provided to participants under this Contract.

~~10.~~ **Capitated Service** means any Medi-Cal Covered Service for which Contractor receives Capitation payment.

Exhibit E, Attachment 1
Definitions

~~11.~~ **Capitation** means the monthly payment to Contractor for **Medi-Cal** services covered by the Contract.

~~12.~~ **Capitation Rate** means the amount paid per Member per month for services to be provided at-risk.

~~13.~~ **Case Management** means responsibility for referral, consultation, ordering therapy, admission to hospitals, follow-up care, and prepayment approval of referred services. It includes responsibility for location, coordination, and monitoring all medical care on behalf of a Member.

~~14.~~ **Catastrophic Coverage Limitation** means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to Enrollment.

~~15.~~ **Center** means a Facility operated by a PACE Organization where Primary Care is furnished to plan Members.

~~16.~~ **Claims and Eligibility Real-Time System (CERTS)** means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Complete Claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

~~17.~~ **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

~~18.~~ **Contract** means this written agreement between DHCS and Contractor.

~~19.~~ **Contracting Officer** means the single administrator of this Contract appointed by the Director DHCS. On behalf of DHCS, the Contracting Officer shall make all determinations and take all action as are appropriate to implement this Contract, subject to the limitations of the Contract.

Exhibit E, Attachment 1
Definitions

~~20.~~ **Contracting Providers** means a Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home or any other individual or institution that contracts with a Contractor to provide medical services to **Contractor's PACE plan** Members.

~~21.~~ **Contractor's Representative** means the single administrator who is authorized to bind Contractor on all matters related to this contract and take all actions as are necessary to implement Contractor's obligations, subject to the limitations of the Contract.

~~22.~~ **Contractor** means an entity doing business as [PACE Plan Name].

~~23.~~ **Corrective Actions** means specific identifiable activities or undertakings of Contractor which address program deficiencies or problems identified by formal audits or **by CMS or** DHCS monitoring **or oversight** activities.

~~24.~~ **Cost Avoid** means Contractor bills or requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.

~~25~~. **County Department** means the County Department of Social Services (DSS) or other county agency responsible for determining the **applicant or member's** initial and continued eligibility for the Medi-Cal program.

~~26.~~ **Covered Services** means those items and services provided by Contractor under the provisions of ~~W&I~~ **Welfare and Institutions** Code, ~~S~~**s**ection 14132 **and the California State Plan,** except those services specifically excluded under this paragraph, **state law, or the California State Plan**.

A. Covered Services include, but are not limited to:

1) Acute inpatient care, including the following:

a. Ambulance

b. Emergency room care and treatment room services

c. Semi-private room and board

d. General medical and nursing services

e. Medical surgical/intensive care/coronary care unit

Exhibit E, Attachment 1
Definitions

f. Laboratory tests, x-rays and other diagnostic procedures

g. Drugs and biologicals

h. Blood and blood derivatives

i. Surgical care, including the use of anesthesia

j. Use of oxygen

k. Physical, occupational, respiratory therapies, and speech language pathology services

l. Social Services

m. Inpatient Mental Health

2) Interdisciplinary Team Assessment and Treatment Planning

3) Adult Day Health Center and Clinic Services as set forth in **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ections 54309 **through** 54323 including, but not limited to, the following:

a. Primary Care, including Physician and nursing services

b. Social work services

c. Restorative therapies, including physical therapy and occupational therapy

d. Personal care and supportive services

e. Nutritional counseling

f. Recreational therapy

g. Meals

h. Transportation

4) Home Care Services, including ~~the following:~~

~~a.~~ Home Health Services

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Exhibit E, Attachment 1
Definitions

~~b. In-Home Supportive Services~~

5) Outpatient mental health services

6) Drugs and biologicals

7) Laboratory tests, x-rays, and other diagnostic procedures

8) Medical specialty services including, but not limited to the following:

a. Anesthesiology

b. Audiology

c. Cardiology

d. Dentistry

e. Dermatology

f. Gastroenterology

g. Gynecology

h. Internal medicine

i. Nephrology

j. Neurosurgery

k. Oncology

l. Ophthalmology

m. Oral surgery

n. Orthopedic surgery

o. Otorhinolaryngology

p. Plastic surgery

Exhibit E, Attachment 1
Definitions

q. Pharmacy consulting services

r. Podiatry

s. Psychiatry

t. Pulmonary disease

u. Radiology

v. Rheumatology

w. General surgery

x. Thoracic and vascular surgery

y. Urology

9) Nursing Facility care, including the following:

a. Semi-Private room and board

b. Physician and skilled nursing services

c. Custodial care

d. Personal care and assistance

e. Drugs and biologicals

f. Physical, occupational, recreational therapies, and speech language pathology, if necessary

g. Social services

h. Medical supplies and appliances

10) Other services determined necessary by the IDT to improve and maintain the ~~participant's~~ **member's** overall health status

11) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items~~.~~

12) Major Organ Transplants

B. Covered Services do not include:

1) Any service that has not been authorized by the IDT, even if it is a required service, unless it is an emergency service;

2) Services rendered in a non-emergency setting or for a non-emergency reason without Prior Authorization;

3) Prescription and over-the-counter drugs not prescribed by Contractor's Physician;

4) In an inpatient Facility, private room and private duty nursing services (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the IDT as part of the Member's plan of care);

5) Cosmetic surgery, ~~unless~~ **which does not include surgery that is** required for improved functioning or a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy;

6) Experimental ~~drugs and~~ medical, surgical or other health procedures;

7) Care in a government hospital (VA, federal/state hospital);

8) Any services rendered outside of the United States, except in accordance with 42 CFR, ~~Sections~~ 424.122 and 424.124**, or as permitted under the Medi-Cal approved Medicaid Plan**;

~~27.~~ **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

~~28. **Days** shall mean calendar days, unless otherwise specified in Contract.~~

~~29.~~ **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicaid program.

Exhibit E, Attachment 1
Definitions

~~30.~~ **Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program~~, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs~~.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

~~31.~~ **Diagnosis of AIDS** means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), ~~United States Department of Health and Human Services (~~**DHHS**~~)~~, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

~~32.~~ **Dietitian/Nutritionist** means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Bus~~.iness and~~ **&** Prof~~.essions~~ Code, **c**~~C~~hapter 5.65, **s**~~S~~ections 2585 and 2586).

~~33.~~ **Director** means the Director of the State of California Department of Health Care Services

~~34.~~ **Disenrollment** means the Department-approved discontinuance of a Member's entitlement to receive Covered Services under the terms of this Contract and the deletion from the approved list of Members furnished by the Department to Contractor.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health facility licensed pursuant to Health and Safety Code, chapter 2, division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, section 14105.98.

Exhibit E, Attachment 1
Definitions

Dual-Eligible Beneficiary means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

~~35.~~ **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in Contractor's Service Area, 55 years of age or older, determined by DHCS as ~~eligible for~~ **requiring** nursing home level of care, and **is** able to live in a community setting without jeopardizing his **or** ~~(~~her~~)~~ health or safety, **with one of the following aid codes:**~~.~~

Family aid codes 01, 02, 0A, 3E, 3L, 3M, 3N, 3U, 3W, M3
SPD aid codes 20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H
Adult aid codes 53, 81
Adult Expansion aid codes M1, 7U, L1, L6

~~36.~~ **Emergency Management Plan** means a strategy developed with steps for response and recovery from an unplanned event that could cause death or significant injury to employees, eligible beneficiaries or the public; or that can shut down business, disrupt operations, stop claims payment, cause physical or environmental damage or threaten the facility's financial standing or public image. Numerous events can be "emergencies" including: fire, hazardous material incident, flood or flash flood, hurricane, tornado, winter storm, earthquake, communications failure, radiological accident, civil disturbance, loss of a key supplier or customer or an explosion.

~~37. **Emergency Medical Condition** means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~

~~A. Placing the health of the individual in serious jeopardy,~~

~~B. Serious impairment to bodily function, or~~

~~C. Serious dysfunction of any bodily organ or part.~~

~~38. **Emergency Services** means those health services needed to evaluate or stabilize an Emergency Medical Condition.~~

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~~39.~~ **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in the plan during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

Encounter Data means the information that described health care interaction between Members and providers relating to the receipt of any item(s) or service(s) by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818.

~~40.~~ **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of Contractor's plan~~, in accordance with the provisions of Title 22, CCR, Section 53420~~.

41. **Enrollment Agreement** means a Contract between Contractor and Member which establishes the terms and conditions for Enrollment.

~~42.~~ **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract**;** or

B. Maintained by a provider to provide services on behalf of Contractor.

~~43.~~ **Federal Financial Participation** means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 U.S.C. § 1396d(l)(2)(B)).

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State.

~~44.~~ **Financial Performance Guarantee** means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's Capitation.

~~45.~~ **Financial Statements** means the Financial Statements as defined by Generally Accepted Accounting Principles (GAAP) which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying

footnotes prepared in accordance with GAAP. All documents are prepared in accordance with GAAP.

~~46.~~ **Fiscal Year (FY)** means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, **and** the federal Fiscal Year is October 1 through September 30.

General and Administrative Expenses means expenses as defined in California Code of Regulations, title 28, section 1300.78. These expenses are not part of Allowed Medical Expenses, but are part of Net Capitation Payments.

~~47.~~ **Grievance** means a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.

Health Maintenance Organization (HMO) means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

~~48.~~ **Health Plan Employer Data and Information Set (HEDIS)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

~~49. **Health Promotion and Disease Prevention Care** means those medical examinations, procedures, and/or tests provided by Contractor with the objective of promoting positive and optimum health, to prevent departure from baseline health, and to cure or prevent disabling illness after the onset of certain diseases. The protocols for Health Promotion and Disease Prevention Care provided by Contractor are deemed appropriate for a frail population when approved by the governing body, the Medical Advisory Committee of Contractor and the DHCS.~~

Indian Health Programs means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care

Exhibit E, Attachment 1
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Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area (California Code of Regulations, title 22, section 55000).

~~50.~~ **Interdisciplinary Team** means a team composed of ~~at least the following members to comprehensively assess and meet the individual needs of each Member~~ **members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of members:**

A. Primary Care ~~Physician~~ **Provider;**

Primary medical care must be furnished to a member by any of the following:

1) A primary care physician.

2) A community-based physician.

3) A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.

4) A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.

B. Registered Nurse**;**

C. **Master's –level** Social Worker**;**

D. Physical Therapist**;**

E. Occupational Therapist**;**

F. Recreational Therapist or Activity Coordinator**;**

G. Dietician**;**

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H. PACE Center Manager**;**

I. Home Care Coordinator**;**

J. Personal Care Attendant or his or her representative**; and**

K. Driver or his or her representative

Integrated Systems of Care Division (ISCD) means the division within DHCS that manages and monitors the Contract.

~~51.~~ **Intermediate Care Facility (ICF)** means a Facility ~~which~~ **that** is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in **California Code of Regulations,** ~~T~~**t**itle 22, ~~S~~**s**ection 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with section 1340, Health & Safety Code.

~~52. **Long-Term Care Division (LTCD)** means the division within DHCS that manages and monitors the Contract.~~

~~53.~~ **Marketing** means any activity conducted **by or** on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. **Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.**

Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees.

~~54.~~ **Marketing Representative** means a person who is engaged in Marketing activities on behalf of Contractor ~~through direct employment by Contractor~~.

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~~55.~~ **Medi-Cal Eligibility Data System (MEDS)** means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need Beneficiary Identification Cards.

Medical Expenses means Contractor's actual expenses incurred and accounted for in accordance with the Generally Accepted Accounting Principles for Covered Services delivered to Members during each period. This includes expenses incurred for provider payment incentive programs, medical management, utilization management and quality assurance activities, but excludes administrative costs as defined in California Code of Regulations title 28, section 1300.78 as well as pass-through items such as intergovernmental transfers, Hospital Quality Assurance Fees, and MCO/Sales taxes.

Medical Loss Ratio (MLR) means the Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by Contractor, by county. The MLR will be measured by the same county that was used in the development of the capitation rates paid to the Contractor, under this Contract. The calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, MCO/Sales taxes, and the Health Insurance Providers Fee (HIPF).

If a Staff Model Contractor does not account for Medical Expenses specifically by line of business and uses an allocation methodology, the MLR shall be the average MLR of all other Medi-Cal managed care contractors operating within the county in which Contractor operates. In such cases, Staff Model Contractor's MLR shall be excluded from the average MLR.

~~56.~~ **Medi-Cal Managed Care Division** means the division within the DHCS that has the responsibility, along with ~~the Long-Term Care Division~~ **ISCD**, ~~of~~ **for** monitoring managed care Contracts.

~~57.~~ **Medical Records** means written documentary evidence of treatments rendered to plan Members.

~~58.~~ **Medically Necessary** or **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.

~~59.~~ **Member** means any Eligible Medi-Cal Beneficiary who has enrolled in Contractor's plan in accordance with the provisions of **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53420. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member**"**.

~~60. **This provision intentionally left blank.**~~

National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

NCQA Licensed Audit Organization is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

Net Capitation Payments means Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to providers, such as for intergovernmental transfers and HQAFs, and the State, such as for Contractor premium/Sales taxes, Hospital Quality Assurance Fees, and the Health Insurance Providers Fee (HIPF). Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with Generally Accepted Accounting Principles (GAAP).

~~61.~~ **Non-Emergency Medical Transportation** means ~~inclusion of services outlined~~ **ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per** ~~in~~ **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~ **s**ections **51323**, 51231.1 and 51231.2 rendered by licensed providers.

~~62.~~ **Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated Members by ambulances, litter vans or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

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~~63.~~ **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner or ~~p~~**P**hysician assistant authorized to provide Primary Care under Physician supervision.

Not Reported means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

~~64.~~ **Nurse** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Nursing Facility Level of Care means the Level of Care meeting criteria established in the department's approved Medi-Cal Manual of Criteria for Medi-Cal Authorization that includes California Code of Regulations, title 22, sections 51334 and 51335.

~~65.~~ **Other Healthcare Coverage Sources** (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding Tort Liability.

~~66.~~ **Outpatient Care** means treatment provided to a Member who is not confined in a health care Facility. ~~Outpatient care is associated with treatment in a hospital that does not necessitate an overnight stay, e.g., emergency treatment.~~

Outpatient Mental Health Services means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

~~67.~~ **PACE** stands for the Program of All-Inclusive Care for the Elderly.

PACE Center means the location designated by Contractor at which Members shall receive PCP services.

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~~68.~~ **PACE Organization** means an organization which meets the requirements of 42 CFR Section 460.60**, and all other state and federal statutes and regulations applicable to PACE plans,** and has signed a PACE Program agreement with ~~the Centers for Medicare and Medicaid Services (~~CMS~~)~~ and ~~the Department of Health Care Services~~ **DHCS**.

Person-Centered Planning means an ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences.

~~69.~~ **Physician** means a person duly licensed as a Physician by the Medical Board of California.

~~70.~~ **Physician Incentive Plan** means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

~~71.~~ **Policy Letter** means a document that has been dated, numbered, and issued by the ~~Medi-Cal Managed Care Division~~ **MMCD** or ~~the~~ ~~Long-Term Care Division~~ **ISCD** that clarifies regulatory or contractual requirements.

~~72.~~ **Policy Statement** means a detailed goal statement in which Contractor commits to meet all aspects of this Contract.

~~73.~~ **Post-Payment Recovery** means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Post Stabilization Care means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. They are not emergency services, which POs are obligated to cover. Rather, they are non-emergency services that the PO should approve before they are provided outside the service area.

~~74.~~ **Preventive Care** means health care designed to prevent disease and/or its consequences. ~~There are three levels of Preventive Care; primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.~~

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~~75.~~ **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Dentist means a dentist responsible for supervising, coordinating, and providing dental care to Member.

~~76.~~ **Primary Care Physician (PCP)** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients **and serves as the medical home for Members**.~~; for initiating referrals for specialist care; and for working in conjunction with an IDT to ensure continuity of patient care and effective Case Management. A Primary Care Physician~~ **The** ~~(~~PCP~~)~~ is a ~~Physician~~ **general practitioner, internist, pediatrician, family practitioner, or** who ~~has limited his/her practice of medicine to general~~ obstetrician/gynecologist **(OB/GYN).**

~~77.~~ **Primary Care Provider (PC)** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a ~~Primary Care Physician~~ ~~(~~**PCP**~~)~~ or Non-Physician Medical Practitioner.

~~78.~~ **Prior Authorization** means ~~the~~ **a formal** process ~~by which Contractors approve, usually in advance of the rendering, requested medical services. This is part of the Utilization Management System~~ **requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.**

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.

Prior Authorization Request means a method by which practitioners seek approval from Contractor to render medical services. Contractor's IDT is responsible for granting approval to providing specific, non-emergency medical services in advance of rendering such services.

~~79.~~ **Procedures** means a detailed description of how Contractor and its designees ~~shall~~ **will** achieve the goal. It ~~shall~~ **will** contain details of systems, processes, and

lines of communication integral to achieving the policy **as stated in Contractor's Policy and Procedures manuals.**

~~80.~~ **Program Director** means a person responsible for oversight and administration of the entity as specified by 42 CFR Section 460.60(b).

~~81.~~ **Protocols** means a written plan of delivery of services and must identify how the services are delivered for standard, consistent care to Members.

~~82.~~ **Provider of Services** means any individual, partnership, clinic, group, association, corporation, institution or public agency meeting applicable standards for participation with the Medi-Cal program as defined in **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR~~, ~~Division 3, Subdivision 1, Chapter 3, Article 3 (commencing with S~~**s**ection 51200 **et seq.**~~)~~.

~~83.~~ **Provider Appeal** means an Appeal concerning the authorization or denial of a service**,**~~;~~ denial, deferral or modification of a Prior Authorization request on behalf of a Member or the processing of a payment or non-payment of a claim by the Contractor.

~~84.~~ **Quality Assurance (QA)** means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both health services and administrative and support services.

~~85.~~ **Quality Improvement (QI)** means the result of an effective Quality Improvement **System** ~~program which objectively and systematically monitors and evaluates the quality and appropriateness of care and services to Members through Quality of Care studies and other health related activities.~~

~~86.~~ **Quality Improvement System (QIS)** means ~~consisting of~~ systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and contract language. **Contractor** ~~The plan~~ must have processes in place~~, which~~ **that** measure the effectiveness of care, identify~~y~~**ies** problems, and implement**s** improvement on a continuing basis. ~~The QIS is referred to as Quality Assessment and Performance Improvement (QAPI) by the Centers for Medicare/Medicaid Services (CMS).~~

~~87.~~ **Quality of Care** means the degree to which health services for individuals and populations increase**s** the likelihood of desired health outcomes and are consistent with current professional knowledge.

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Quality Incidents means an unexpected occurrence that caused a Member death or serious physical or psychological injury that included permanent loss of function. Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.

~~88.~~ **Quality Indicators** means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

~~89.~~ **Reinsurance** means coverage secured by Contractor, which limits the amount of risk or liability assumed under this Contract.

Rural Health Clinic (RHC) means an entity defined in California Code of Regulations title 22, section 51115.5.

Safety-Net Provider means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include FQHCs; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

~~90.~~ **Seniors and Persons with Disabilities (SPD)** means Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary).

Sensitive Services means those services related to:

A. Sexually transmitted diseases (STDs)

B. HIV testing

Screening, Brief Intervention, and Referral to Treatment (SBIRT) means services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

~~91.~~ ~~**Sentinel Event** means an unexpected occurrence that caused a Member death or serious physical or psychological injury that included permanent loss of~~

~~function. Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.~~

~~92.~~ **Service Area** means ~~geographical area comprised of those areas designated by the U.S Postal Service ZIP Codes that have been proposed by Contractor and approved in writing by the Department, after careful evaluation to ensure adequate access to health care services by plan Members who reside therein~~ **the county or counties in which Contractor is approved to operate under the terms of this Contract. A Service Area may have designated ZIP codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.**

~~93.~~ **Service Location** means any location at which a Member obtains any health care services provided by Contractor under the terms of this Contract.

~~94.~~ ~~**Service Site** means the location designated by Contractor at which Members shall receive PCP services.~~

~~95.~~ **Skilled Nursing Facility (SNF)** means, as defined in **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR, subdivision S~~**s**ection 51121(a), any institution, place, building or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home**,**" "convalescent hospital**,**" "nursing home**,**" or "nursing facility".

Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service means those services identified in 9 CCR section 1810.247, including but not limited to:

A. Rehabilitative Mental Health Services, including:

a. Mental health services;

b. Medication support services;

c. Day treatment intensive;

d. Day rehabilitation;

e. Crisis intervention;

f. Crisis stabilization;

g. Adult residential treatment services;

h. Crisis residential treatment services;

i. Psychiatric health facility services;

j. Psychiatric Inpatient Hospital Services;

k. Targeted Case Management;

l. Psychiatrist Services;

m. Psychologist Services;

n. EPSDT Supplemental Specialty Mental Health Services; and

o. Psychiatric Nursing Facility Services.

~~96.~~ **State** means the State of California.

~~97.~~ ~~**State Employee** includes, but is not limited to:~~

~~A. The Director of the Department of Health Care Services, and~~

~~B. The following appointive and civil services employees of the Department:~~

~~Chief Deputy Director~~

~~Deputy Director~~

~~Chief Counsel~~

~~Division Chiefs~~

~~Branch Chiefs~~

~~Section Chiefs; and or~~

~~Office, Unit, Bureau, Project and Program Chief or Managers~~

~~98.~~ **State Officer** means

A U.S. Senator or member of Congress representing California

The Governor

The Lieutenant Governor

The Secretary of State

The Controller

The Treasurer

The Attorney General

The State Superintendent of Public Instruction**; or**

A member of the Legislature~~; or~~

~~A secretary of a State Agency~~

Subacute Care means, as defined in California Code of Regulations, title 22 section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

~~99.~~ **Subcontract** means a written agreement entered into by Contractor with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Member~~s.~~**; and**

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for Contractor specifically related to fulfilling Contractor's obligations to DHCS under the terms of this Contract.

~~100.~~ **Sub-Subcontractor** means any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the

purpose of providing any goods or services connected with the obligations under this Contract.

~~101. **Substantial Financial Interest** means the ownership of:~~

~~A. Common stock~~

~~B. Preferred stock~~

~~C. Warrants~~

~~D. Options~~

~~E. Loans~~

~~F. Partnership interests~~

~~G. Debt instruments~~

~~H. Any ownership interest which consists of, or is convertible to, equity investments in this Contractor or this Contractor's subcontractor(s) or sub-subcontractor(s). Ownership interest in terms of fair market value shall not be less than the greater of:~~
~~1) $1,000~~

~~2) Five percent or more of the total fair market value of all equity investments in the entity, including ownership interests convertible to such investments.~~

~~102.~~ **Supplemental Security Income (SSI)** means the program authorized by Title XVI of the Social Security Act **(42 U.S.C. §§ 1381-1383f)** for aged, blind, and disabled persons.

Telehealth means a method of delivering health care services by using 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 a separate location from the health care provider. Telehealth facilitates the Member's self-management and caregiver support for the Member.

~~103.~~ **Third Party Tort Liability (TPTL)** means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal

obligation or as a result of, or the fault or negligence of, third parties (e.g., auto accidents**,** ~~or~~ other personal injury casualty claims**,** or Workers' Compensation Appeals).

~~104.~~ **Unusual Incident or Injury** means one which threatens the welfare, safety or health of any Member, and which is not consistent with the Center's routine operation or Member care. Any incident that meets the ~~level one and level two~~ **quality incident** criteria established by the CMS HPMS reporting guidelines, regardless of where it occurred, must be reported.

~~105. **Unusual Occurrences, Fires, and Explosions** means occurrences such as epidemic outbreaks, poisonings, catastrophes or major accidents, and fires or explosions which occur in or on the premises and threaten the welfare, safety or health of Members, employees or visitors.~~

~~106.~~ **Unusual or Seldom-Used Health Care Services** means those services of which 12 or fewer transactions are performed by Contractor in any one year period.

~~107.~~ **Urgent Care** means on-site services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Off-site Urgent care, as defined by federal PACE regulation 42 CFR ~~Section~~ 460.100(e)(3), means the care provided to a PACE ~~participant~~ **member** who is out of the PACE Service Area, and who believes ~~their~~ **his or her** illness or injury is too severe to postpone treatment until they return to the Service Area, but their life or function is not in severe jeopardy. ~~For purposes of this provision, "Urgent Care" means "on-site Urgent Care."~~

Utilization means the rate patterns of service usage or types of service occurring within a specified time. Inpatient Utilization is generally expressed in rates per unit of population-at-risk for a given period; e.g., the number of hospital admissions per 1,000 persons enrolled in an HMO/per year.

~~108.~~ **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

Working day(s) means State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
Program Terms and Conditions

1. Governing Law

In addition to Exhibit C, provision 14~~.~~ ~~Governing Law~~, Contractor also agrees to the following:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create Contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law ~~or the Contract is amended for conformity pursuant to this provision, paragraph B~~. Except for provision 16. Sanctions, **and provision 17. Liquidated Damages below** ~~of this Attachment~~, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. In the event any provision of this Contract is held invalid by a court, the remainder of this Contract shall not be affected. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

~~B.~~ Any provision of this Contract which is in conflict with current or future applicable federal and ~~S~~**s**tate laws or regulations, ~~including but not limited to, 42 CFR Part 460 and Chapter 8.75 (commencing with section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code,~~ is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties ~~hereto~~ even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of provision 14. paragraph C**.**, Termination – Contractor **below**. The parties shall be bound by the terms of the amendment until the effective date of the termination.

~~C~~**B**. All existing **final** Policy Letters issued by MMCD and ~~LTCD~~ **ISCD** applicable to PACE ~~are hereby incorporated into this Contract~~ **can be viewed at www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx** and shall be complied with by Contractor. All Policy Letters issued by MMCD and ~~LTCD~~ **ISCD**, applicable to PACE, subsequent to the effective

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date of this Contract shall provide clarification of Contractors obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated obligations pursuant to changes in ~~S~~**s**tate or federal statutes or regulations, or pursuant to judicial interpretation.

In the event DHCS determines that there is an inconsistency between this Contract and a Policy Letter, the Contract shall prevail.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

In addition to Exhibit C, provision 2. ~~Amendment,~~ Contractor also agrees to the following:

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within **ten** ~~(10)~~ **calendar** days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal **at** any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the ~~S~~**s**tate Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the ~~Long-Term~~ **Integrated Systems of** Care Division and Medi-Cal Managed Care Program shall be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes shall vary widely over the life of the Contract. The parties agree that the development of a

system that has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place. DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the DHCS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

5. Delegation ~~O~~o~~f~~f Authority

A. DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of DHCS shall appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, shall make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and ~~S~~**s**tate laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to Contractor.

B. Contractor shall designate a single administrator; hereafter called the "Contractor's Representative". Contractor's Representative, on behalf of Contractor, shall make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and ~~S~~**s**tate laws and regulations. Contractor's Representative may delegate his~~/~~ **or** her authority to act to an authorized representative through written notice to the Contracting Officer. Contractor's Representative shall be empowered to legally bind Contractor to all agreements reached with DHCS.

C. Contractor shall designate Contractor's Representative in writing **and shall notify the Contracting Officer**. ~~Such designation shall be submitted to the Contracting Officer~~, in accordance with Exhibit E, Attachment 2, provision 10. ~~Notices.~~

6. Authority of the State

~~A.~~ Sole authority to establish, define or determine the reasonableness, the necessity and level and scope of covered benefits under the PACE program administered in this Contract or coverage for such benefits or the eligibility of the beneficiaries or providers to participate in the PACE resides with DHCS.

~~B.~~ Sole authority to establish or interpret policy and its application related to the above areas ~~shall~~ **will** reside with DHCS.

~~C.~~ Contractor may not make any limitations, exclusions or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation or undertaking continued or made a part of this Contract shall be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party shall have the right to invoke any remedy available under this Contract or under law, notwithstanding such forbearance or indulgence.

8. Obtaining DHCS Approval

Contractor shall obtain written approval from DHCS in Exhibit E, Attachment 3, provision 5. ~~DHCS~~ Approval Process, prior to implementing, amending or using any of the following:

Exhibit E, Attachment 2
Program Terms and Conditions

A. Providers of medical and dental covered services, except for providers of seldom used or unusual services as determined by the DHCS~~.~~**;**

B. Facilities and site expansions~~.~~**;**

C. Subcontracts and sub-subcontracts with providers or management services.**;**

D. Marketing activities.**;**

E. All Marketing materials, promotional materials, and public information releases relating to performance under this Contract, Enrollment Agreement: Terms and Conditions, and Member newsletters~~.~~**;**

F. Member Grievance procedure, including forms~~.~~**;**

G. Member Enrollment and Disenrollment procedures, including forms~~.~~**;**

H. Utilization control mechanism, including a description of the system to evaluate the quality of medical and dental care, conduct professional review activities, assess the performance of medical personnel, and monitor utilization and cost effectiveness~~.~~**;**

I. Any other protocol, policy or procedure requiring approval under this Contract~~.~~**; and**

J. Any deviation or change from the approved organizational structure.

9. Certifications

Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, provision 11~~. Certifications~~, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account or other Contract required data submitted, pursuant to the requirements of this Contract, Contractor's Representative or his~~/~~ **or** her designee shall certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's

knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

10. Notices

A. All Notices

All notices to be given under this Contract shall be in writing and shall be deemed to have been given when mailed~~,~~ to DHCS or Contractor at the following addresses:

Chief, ~~Long-Term Care Division~~
Integrated Systems of Care Division
Department of Health Care Services
1501 Capitol Avenue, MS ~~0018~~ **4502**
P.O. Box 9974**37**~~13~~
Sacramento, CA 95899-74**37**~~13~~

PACE Plan Name
dba: PACE Plan Name
Address
city, CA zip code

B. Notification of Intent Not to Renew

Should either party elect not to renew this Contract, this decision shall be conveyed in writing to the other party at least 90 days prior to the expiration of this Contract.

11. Term

The Contract shall become effective ~~[DATE]~~ **July 1, 2020**, and shall continue in full force and effect through ~~June 30, 2020~~ **December 31, 2024** subject to the provisions of Exhibit B, provision 1~~. Budget Contingency Clause~~**, CMS waiver approval**, and Exhibit D(F), provision 9. Federal Contract Funds.

12. Service Area

Contractor must serve a defined Service Area, identified by zip codes, approved by DHCS and CMS. Changes in the Service Area must be pre-approved by DHCS and CMS.

13. Contract Extension

DHCS shall have the exclusive option to extend the term of the Contract **for any Service Area** during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHCS may invoke up to three separate extensions of up to

twelve (12) months each. Contractor ~~shall~~ **will** be given at least nine months prior written notice of DHCS' decision on whether or not it shall exercise this option to extend the Contract.

Contractor shall provide written notification to DHCS of its intent to accept or reject the extension within five ~~(5)~~ ~~S~~**s**tate working days of the receipt of the notice from DHCS.

14. Termination for Cause and Other Terminations

In addition to Exhibit C, provision 7~~. Termination for Cause~~, Contractor also agrees to the following:

A. Termination – State or Director

~~The State or Director may terminate this Contract for good cause shown at any time, subject to the provisions of W&I Code, Section 14304(a). Failure to comply with any of the terms of this Contract shall constitute cause for termination.~~

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the state.

DHCS shall notify Contractor of intent to terminate the contract at least six (6) months prior to the effective date of termination, except in cases described below in Paragraph B. Termination for Cause.

B. ~~Mandatory~~ Termination **for Cause**

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) DHCS may terminate this Contract as stated in 42 USC Section 1395eee(e)(5)(B), and 42 CFR 460.50, including but not limited to:

a) Either DHCS determines there are significant deficiencies in the quality of care provided to enrolled members, or the Contractor has failed to comply substantially with conditions for a program or provider under this section or Section 1396u-4 of this title; and

b) Contractor has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

3) Notification shall be given at least six months prior to the effective date of termination, except in cases described below in Paragraph C.

~~1~~**4**) ~~The Director~~ **DHCS** shall terminate this Contract in the event that~~,~~**:** the Secretary, DHHS, determines that Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Notification ~~shall~~ **will** be given by DHCS at least 60 **calendar** days prior to the effective date of termination.

~~2~~**5**) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract shall be immediately terminated. Notification ~~shall~~ **will** state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B., item 2) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 18.~~Under these circumstances,~~ t**T**ermination **of this Contract** shall be effective on the last day of the month in which the Secretary or DHHS makes such determination, provided that DHCS provides Contractor with at least 60 **calendar** day~~'~~s**'** notice of the termination. The termination of this Contract shall be effective on the last day of the second full month ~~following~~ **from** the date of the notice of termination. Contractor agrees that 60 **calendar** days**'** notice is reasonable~~ under the terms of W&I Code, Section 14304~~. **Termination under this section does not relieve Contractor of its obligations under Provision 15 below. Phaseout Requirements shall be performed after Contract termination.**

C. Termination - Contractor

~~Contractor may terminate this Contract at any time by giving a minimum 90 day written notice to the Director to that effect, stating the reasons for the termination. The termination shall become effective on the last day of the second calendar month following the month in which notice of termination was given.~~

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the Capitation Rates determined by DHCS, or if DHCS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a ~~S~~**s**tate or federal change in the Medi-Cal program or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis.

For any Contract termination initiated by the Contractor, the Contractor must provide at least 90 days prior notice to CMS and DHCS, and at least 60 days prior notice to members.

DHCS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in Provision 15 below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension shall automatically terminate on the effective date of any termination of this Contract pursuant to sections A, B, or C of this provision or upon expiration of the term of this Contract. Contractor shall be responsible for providing Covered Services to Members until the termination or expiration of this Contract and shall remain liable for the processing and payment of invoices and statements for Covered Services provided to Members prior to such expiration or termination. All eligible Medi-Cal beneficiaries shall be transferred to a fee-for-service or other

appropriate service status when this Contract has been terminated. **The Contractor shall provide assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.**

E. Notice to Members of Transfer of Care

Contractor shall develop and implement a detailed written plan for phase-down in the event of termination which includes the process for informing Members, the community, CMS and the ~~S~~**S**tate in writing about termination and transition procedures; and steps that shall be taken to help assist Members to obtain reinstatement of conventional Medi-Cal benefits, transition their care to other providers, and terminate Marketing and Enrollment activities. **At least 60 days prior to the proposed termination date of the Contract, Contractor must submit the detailed written plan for phase-down to DHCS for approval prior to implementation by the Contractor. Contractor must modify the detailed written plan for phase-down to obtain approval by DHCS.** ~~Contractor shall provide assistance to each Member in obtaining necessary transitional care through appropriate referrals and making the Member's medical records available to new providers.~~

15. ~~Turnover and~~ Phaseout Requirements

~~A plan that details the manner in which beneficiaries shall be shifted to other sources of care or be told of the cessation of the Contract.~~

A. ~~Turnover Requirements~~

~~Prior to the termination or expiration of this Contract and upon request by DHCS, Contractor shall assist DHCS in the orderly transfer of Member medical care. In doing this, Contractor shall make available to DHCS copies of Medical Records, Member files, and any other pertinent information; including information maintained by any subcontractor, necessary for efficient Case Management of Members, as determined by the Director. Costs of reproduction shall be borne by DHCS. In no circumstances shall a Medi-Cal Member be billed for this service.~~

DHCS shall withhold the lesser of an amount equal to 10% of the last month's Service Area capitation payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the

last month of the Operations Period for each Service Area until all activities required during the Phase-out Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phase-out activities for each Service Area are completed by the end of the Phase-out Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the wirthhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phase-out Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHCS or to a successor Contractor. The Contractor shall not provide services to Members during the Phase-out Period.

90 calendar days prior to termination or expiration of this Contract and through the Phase-out Period for each Service Area, the Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. Under no circumstances will a Medi-Cal Member be billed for this activity.

BC. ~~Phase-out Requirements~~

Phase-out for this Contract shall consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phase-out for the Contract shall consist of the ~~resolution~~ **completion** of all financial and reporting obligations of **the** Contractor. **The** Contractor ~~shall~~ **will** remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. **The** Contractor ~~shall~~ **will** submit to DHCS all reports required in Exhibit A, Attachment 17~~, Reporting Requirements~~, for the period from the last submitted report through the expiration or termination date.

All data and information provided by Contractor ~~shall~~ **will** be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

D. Phase-out Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phase-out related activities are non-payable items.

16. Sanctions

If, as set forth in 42 CFR 460.42(b)(2), CMS denies medical assistance payment to DHCS for services furnished under this Contract based on the Contractor committing one or more violations specified in 42 CFR 460.40, then DHCS shall not be responsible for payment to Contractor in the amount of the CMS denial, and DHCS may recover any overpayment from Contractor based on the CMS payment denial either through an offset or direct reimbursement from Contractor.

Contractor is subject to sanctions and civil penalties taken pursuant to 42 CFR 460.4, 460.40 through 460.54, and 460.194 Welfare and Institutions Code Section 14304 and California Code of Regulations, title 22, section 53872; however, such sanctions and civil penalties may not exceed the amounts allowable pursuant to 42 CFR, 438.704. If required by DHCS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance.

A. In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations**,** ~~or for good cause shown,~~ DHCS may impose sanctions provided in ~~W&I~~ **Welfare and Institutions** Code, ~~S~~**s**ection 14304 and ~~Title~~ **California Code of Regulations title** 22, ~~CCR,~~ ~~S~~**s**ection ~~53350~~ **53872 as modified for purposes of this Contract. California Code of Regulations, title 22, section 53872 is so modified as follows:** ~~Good cause includes, but is not limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.~~

1) Subsection (b)(1) is modified by replacing "Article 2" with "Article 6"

2) Subsection (b)(2) is modified by replacing "Article 3" with "Article 7"

Exhibit E, Attachment 2
Program Terms and Conditions

~~If required by DHCS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance.~~

B. **The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of title 22, CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).**

C. For purposes of Sanctions, good cause includes, but is not limited to, the following:

1) Three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.

2) In the case of Exhibit A, Attachment 4 Quality Improvement System, the Contractor consistently fails to achieve the minimum performance levels, or receives a "Not Reported" designation on an External Accountability Set measure, after implementation of Corrective Actions.

3) A substantial failure to provide medically necessary services required under this Contract or law to a Member.

4) Non-compliance with the Contract or applicable federal and state law or regulation.

5) Contractor has accrued claims that have not or will not be recompensed. Sanctions in the form of denial of payments provided for under the contract for new enrollees shall be taken, when and for as long as, payment for those enrollees is denied by CMS under 42 CFR 438.730.

E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:

1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and state law or regulation. Contractor cannot delay appointment of temporary management to

provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.

2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;

3) Require Contractor to temporarily suspend or terminate personnel or subcontractors.

4) Take other appropriate action as determined necessary by DHCS.

17. ~~Professional Review System~~ Liquidated Damages

~~Use a professional review system in accordance with Title 22, CCR, Section 53280, for evaluating the appropriateness and quality of the Covered Services provided to Members and for periodically reviewing the performance of health and dental personnel, the utilization of services and facilities, costs, and the standards for acceptable medical and dental care.~~

A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and state law or regulation. Therefore, it is agreed by the state and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the state shall result:

a. Proving such damages shall be costly, difficult, and time-consuming;

b. Should the state choose to impose liquidated damages, Contractor shall pay the state those damages for not providing or performing the specified requirements;

c. Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

d. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

e. DHCS may, at its discretion, offset liquidated damages from Capitation Payments owed to Contractor.

2) Imposition of liquidated damages as specified in paragraphs B. and C., below shall follow the administrative processes described below.

3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by federal and state law or regulation, not provided or performed,

4) Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in paragraph C below.

5) If Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in paragraph C. below.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the state's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.

DHCS may impose liquidated damages of $25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in provision 11 above.

If DHCS determines that a delay or other non-performance was caused in part by the state, DHCS will reduce the liquidated damages proportionately.

The terms and sanctions provided in W&I Code section 14197.7 shall apply to PACE plans.

C. Liquidated Damages for Violation of Contract Terms or Regulations shall at a minimum include:

1) DHCS may impose liquidated damages of $2,500 per day for each violation of Contract requirement not performed in accordance with Exhibit A, Attachment 4, Quality Improvement System, provision 10 and / or paragraph D., until Contract requirement is performed or provided.

2) DHCS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with provision 23.

3) DHCS may impose liquidated damages of $3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, provision 9.

4) DHCS may impose liquidated damages not to exceed $10,000 per violation of this Contract’s requirements, as well federal and state law or regulation.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other Contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

18. Disputes

In addition to Exhibit C, provision 6~~. Disputes~~, Contractor also agrees to the following:

This Disputes section ~~shall~~ **will** be used by Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute shall not preclude DHCS from recouping the value of the amount in dispute from Contractor or from offsetting this amount from subsequent Capitation payment(s). If the amount to be recouped exceeds 25 percent of the Capitation payment, amounts of up to 25 percent ~~shall~~ **will** be withheld from successive Capitation payments until the amount in dispute is fully recouped~~. If a recoupment or offset is later found to be inappropriate, DHCS shall repay Contractor the full amount of recoupment or offset, plus interest at the Pooled Money Investment Rate pursuant to Government Code Section 16480 et. seq.~~

Exhibit E, Attachment 2
Program Terms and Conditions

A. Disputes Resolution by Negotiation

DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

Before issuance of a Contracting Officer's decision, informal discussions between the parties by individuals who have not participated substantially in the matter in dispute shall be considered by the parties in efforts to reach mutual agreement.

B. Notification of Dispute

~~If the parties are not able to resolve a dispute by negotiation as set forth in this provision, paragraph A above w~~**W**ithin 15 **calendar** days ~~or any longer time as agreed by the parties, at its option,~~ **of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the** Contractor ~~may~~ **will** notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which **it** is ~~in dispute~~ **disputing**.

Contractor's notification shall state, on the basis of the most accurate information then available to Contractor, the following:

1) That it is a dispute pursuant to this section~~.~~**:**

2) The date, nature, and circumstances of the conduct which is subject of the dispute~~.~~**;**

3) The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/S~~s~~**S**tate official or employee involved in or knowledgeable about the conduct~~.~~**;**

4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents ~~shall~~ **will** be attached~~.~~**;**

5) The reason Contractor is disputing the conduct~~.~~**;**

6) The cost impact to Contractor directly attributable to the alleged conduct, if any~~.~~**;**

7) Contractor's desired remedy.

The required documentation, including cost impact data, shall be carefully prepared and submitted with substantiating documentation by **the** Contractor. This documentation ~~shall~~ **will** serve as the basis for any subsequent Appeal.

Following submission of the required notification, with supporting documentation, Contractor ~~shall~~ **will comply with the requirements of California Code of Regulations, title 22, section 53851 (d) and** diligently continue performance of this Contract, including matters identified in the Notification of Disputes, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either**:** ~~render a decision or shall request additional substantiating documentation from Contractor, which in the opinion of the Contracting Officer or alternate dispute officer is sufficient to allow the rendering of a decision. Within 30 days of receipt of the additional substantiating documentation requested, a decision shall be rendered. A copy of the decision shall be served on Contractor.~~

~~The Contracting Officer's or alternate dispute officer's decision shall:~~

1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

   a. Countermand the earlier conduct which caused Contractor to file a dispute; or

   b. Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment

provisions contained in Exhibit B~~, Budget Detail and Payment Provisions~~, direct DHCS to comply with that Exhibit; or

2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or ~~A~~ **a**lternate ~~D~~**d**ispute ~~O~~**o**fficer shall have 30 **calendar** days to respond with a decision. Failure to supply additional information required by the Contracting Officer or **a**lternate ~~D~~**d**ispute ~~O~~**o**fficer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with paragraph F~~. Waiver of Claims~~**, below**.

A copy of the decision shall be served on Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have 30 calendar days following the receipt of the decision to file an Appeal of the decision to the Director. All Appeals ~~except as provided in this provision 18. paragraph C2 above~~ shall be governed by Health and Safety Code ~~S~~**s**ection 100171, except for those provisions of Section 100171**, subdivision**(d)**, criteria**(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to paragraph B, Notification of Dispute **above**. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with paragraph F, Waiver of Claims **below**. Contractor shall

exhaust all procedures provided for in this provision 18~~. Disputes~~, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall **comply with the requirements of California Code of Regulations, title 22 section 53851 (d) and** proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an Appeal under paragraph D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to paragraph D. shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any Appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this provision 18~~. Disputes~~, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, provision 4~~. Audit~~, Contractor also agrees to the following:

Contractor shall maintain such books and records necessary to disclose how Contractor discharged its obligations under this Contract. These books and records shall disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Exhibit E, Attachment 2
Program Terms and Conditions

A. Books and Records

These books and records ~~shall~~ **will** include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers~~;~~**,** reports submitted to DHCS~~;~~**,** financial records~~;~~**,** all Medical Records~~;~~**,** medical charts and prescription files~~;~~**,** and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, ~~T~~**t**hese books and records shall be maintained for a minimum of ~~six~~ **ten** years from the **final date of the Contract period or from the date of completion of any audit, whichever is later.** ~~termination date of this or in the event Contractor has been duly notified that the DHCS, DHHS or the Comptroller General of the United States or their duly authorized representatives have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.~~

Additional Recordkeeping Requirements:

1) In accordance with 42 CFR 438.3(u), Contractor shall retain the following information for no less than 10 years:

a. Member Grievance and Appeal records;

b. Base data;

c. MLR reports; and

d. Data, information

20. Inspection Rights

In addition to Exhibit D**(F)**, provision ~~8~~**2**~~. Site Inspection~~, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B., above, Contractor shall allow **the** DHCS, DHHS, the Comptroller General of the United States, **Department of Justice (DOJ), Bureau of Medi-Cal Fraud, DMHC,** and other authorized state agencies or their

duly authorized representatives **or designees, including DHCS' external quality review organization contractor,** to inspect**, monitor** or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all **premises,** books, records, ~~and~~ Facilities**, contracts, computers or other electronic systems,** maintained by Contractor and ~~s~~**S**ubcontractors, pertaining to such services at any ~~reasonable~~ time.

~~Books and r~~**R**ecords **and documents** include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers, reports, financial records and books of account, medical records, prescription files, **laboratory results,** subcontracts, **information systems and procedures,** and any other documentation pertaining to medical and non-medical ~~or dental~~ services ~~for~~ **rendered to** Members. Upon request, ~~at any time during the period of this Contract~~**, through the end of the records retention period specified in Provision 19, paragraph B, above**, Contractor shall furnish any ~~such~~ record, or copy ~~thereof~~ **of it**, to DHCS or any other entity listed in this section, at Contractor's sole expense. ~~At the discretion of DHCS unannounced visits may be made.~~

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor at any time.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of Contractor's Primary Care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right To Monitor

~~The State shall~~ **Authorized state and Federal agencies will** have the right to monitor all aspects of Contractor's operation for compliance with the provisions of this Contract and applicable federal and ~~S~~**s**tate laws and regulations. Such monitoring activities ~~shall~~ **will** include, but are not limited to, inspection and auditing of Contractor, ~~s~~**S**ubcontractor, and provider Facilities, management systems and procedures, and books and records as the Director deems appropriate~~, at any time during Contractor's or other Facility's normal business hours~~. The monitoring activities ~~shall~~ **may** be either announced or unannounced.

Exhibit E, Attachment 2
Program Terms and Conditions

To assure compliance with the Contract and for any other reasonable purpose, the ~~S~~**s**tate and its authorized representatives and designees shall have the right to premises access, with or without notice to Contractor. This shall include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by ~~the~~ **authorized** ~~S~~**s**tate **agencies** ~~or DHCS shall~~ **will** have access to all security areas and Contractor ~~shall~~ **will** provide, and ~~shall~~ **will** require any and all of its subcontractors to provide, reasonable Facilities, cooperation, and assistance to ~~S~~**s**tate representative(s) in the performance of their duties. Access ~~shall~~ **will** be undertaken in such a manner as to not unduly delay the work of Contractor and/or the ~~s~~ **S**ubcontractors(s).

21. Confidentiality of Information

In addition to Exhibit D**(F)**, provision **14**~~13. Confidentiality of Information~~, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with ~~Title~~ 42, CFR, ~~Section~~ 431.300 et seq., **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law~~s~~ pertaining to the release of this type of information. **Contractor is not required to report requests for Medical Records made in accordance with applicable law.**

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by Contractor or its subcontractors, **the** Contractor: (1) ~~shall~~ **will** not use any such information for any purpose other than carrying out the express terms of this Contract~~,~~**;** (2) ~~shall~~ **will** promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law~~,~~**;** (3) ~~shall~~ **will** not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is

releasable under ~~Title~~ 42, CFR, ~~Section~~ 431.300 et seq., W**elfare and Institutions** ~~&I~~ Code, S**s**ection 14100.2, and regulations adopted thereunder~~,~~**;** and (4) ~~shall~~ **will**, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to **the** Contractor by DHCS for this purpose.

22. Pilot Projects

DHCS may establish pilot projects to test alternative models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a contract amendment.

22. Assignments

Contractor shall not assign the Contract, in whole or in part, without the prior written approval of DHCS.

23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a ~~Third-Party Tort Liability (~~TPTL~~)~~ action or make a claim against the estates of deceased Members.

B. Contractor retains all monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the paye~~o~~**e**r of last resort.

D. Cost Avoidance

1) If Contractor reimburses the provider on a ~~fee-for-service~~ **FFS** basis, Contractor shall not pay claims for services provided to a

Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1) If Contractor reimburses the provider on a ~~fee-for-service~~ **FFS** basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties for services provided to Members with OHC codes A, M, X, Y, or Z.

2) In instances where Contractor does not reimburse the provider on a ~~fee-for-service~~ **FFS** basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Contractor shall initiate a Disenrollment for all Members whose eligibility record indicates OHC codes C, F, K, or P, within three ~~S~~**s**tate working days after Contractor becomes aware of the OHC code. Until the Member is disenrolled, Contractor shall Cost Avoid or seek Post-Payment Recovery as specified in paragraphs D**.** and E**.** above.

G. Reporting Requirements

1) Contractor shall ~~submit monthly reports to DHCS, in a format prescribed by DHCS,~~ **maintain reports that** display~~ing~~ claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of

account. The report shall display separate claim counts and dollar amounts for Medicare Part**s** A**,** ~~and Part B~~ **and D**. Reports shall be ~~sent to the Department of Health Care Services, Third Party Liability Division, Cost Avoidance Unit, P.O. Box 2471, Sacramento, CA 95812-2471~~ **made available upon DHCS request**.

2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within **ten** ~~(10)~~ **calendar** days of discovery in automated format as prescribed by DHCS. This information shall be sent to the Department of Health Care Services, Third Party Liability ~~Division~~ **Branch**, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.

3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

24. Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Division of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under ~~Article 3.5 (commencing with Section 14124.70), Part 3, Division 9,~~ Welfare and Institutions Code **section 14124.70**. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability ~~Division~~ **Branch** within **ten** ~~(10)~~ **calendar** days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 **calendar** days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

B. Information to be delivered shall contain the following data items:

Exhibit E, Attachment 2
Program Terms and Conditions

1) Member name~~.~~**;**

2) Full 14 digit Medi-Cal number~~.~~**;**

3) Social Security Number~~.~~**;**

4) Date of birth~~.~~**;**

5) Contractor name~~.~~**;**

6) Provider name (if different from Contractor)~~.~~**;**

7) Dates of service~~.~~**;**

8) Diagnosis code and description of illness/injury~~.~~**;**

9) Procedure code and/or description of services rendered~~.~~**;**

10) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable)~~.~~**;**

11) Amount paid by other health insurance to Contractor or subcontractor (if applicable)~~.~~**;**

12) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable)~~.~~**;**

13) Date of denial and reasons for denial of claims (if applicable)~~.~~**; and**

14) Date of death (if applicable)~~.~~

C. Contractor shall identify to DHCS' Third Party Liability ~~Division~~ **Branch** the name, address**,** and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers or beneficiaries for copies of bills, Contractor shall ~~provide DHCS'~~ **refer the request to the** Third Party Liability ~~Division~~ **Branch** with ~~a copy of any document released as a result of such request,~~ **the information contained in paragraph B., above,** and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to **the California** Department of Health Care Services, Third Party Liability ~~Division~~ **Branch**, Recovery Section, **MS 4720,** P.O. Box ~~2471~~ **997425**, Sacramento, CA ~~95812-2471~~ **95899-7425**.

25. Records Related To Recovery ~~F~~f~~or~~ Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to threatened or pending litigation by or against DHCS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such **a** request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B~~, Budget Detail and Payment Provisions~~, DHCS agrees to pay Contractor for complying with paragraph A**.** ~~, Records~~, above, as follows:

1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with paragraph A. Any third party assisting Contractor with compliance with paragraph A**.** above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with paragraph A**.**, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.

2) If Contractor uses existing personnel and resources to comply with paragraph A**.**, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

a.) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to paragraph A.

b.) Costs for copies of all documentation submitted to DHCS pursuant to paragraph A**.**, subject to a maximum reimbursement of **ten** (10) cents per copied page.

3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

26. Fraud and Abuse Reporting

A. Fraud and Abuse Reporting **For purposes of the exhibit, the following definitions apply:**

Contractor is considered a mandated reporter pursuant to W&I Code, Section 15630(b) and shall comply with the provisions therein.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid 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 recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2; Welfare and Institutions Code section 14043.1(a).)

Conviction or Convicted means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term "convicted" in Welfare and Institutions Code section 14043.1(f).

Fraud means 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 (42 CFR 455.2; Welfare and Institutions Code section 14043.1(i).)

B. **Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:**

1) **Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.**

2) **Contractor shall provide effective training and education for the compliance officer and all employees.**

3) **Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.**

4) **Fraud and Abuse Reporting**

Contractor shall report to the ~~Contracting Officer~~ **DHCS** all cases of suspected fraud and/or abuse, ~~as defined in 42 CFR, Section 455.2,~~ where there is reason to believe that an incident of fraud and/or abuse has occurred, by ~~s~~**S**ubcontractors, Members, providers, or employees. **Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date Contractor first becomes aware of, or is on notice of, such activity**. ~~within 10 State working days of the date when Contractor first becomes aware of or is on notice of such activity.~~

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Program Terms and Conditions

~~Contractor shall establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. Contractor shall notify DHCS prior to conducting any investigations, based upon Contractor's finding that there is reason to believe that an incident to fraud and/or abuse has occurred, and, upon the request of DHCS, consult with DHCS prior to conducting such investigations. Without waiving any privileges of Contractor, Contractor shall report investigation results within 10 State working days of conclusion of any fraud and/or abuse investigation.~~

Fraud reports submitted to DHCS must, at a minimum, include:

a. Number of complaints of fraud and abuse submitted that warranted preliminary investigation.

b. For each complaint which warranted a preliminary investigations, supply:

i) name and/or SSN or CIN;

ii) source of complaint;

iii) type of provider (if applicable);

iv) nature of complaint;

v) approximate dollars involved; and

vi) legal and administrative disposition of the case

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;

b. E-fax at (916) 440-5287; or

c. U.S. Mail at:

Department of Health Care Services

Integrated Systems of Care Division
Attention: Contract Management Unit
P.O. Box 997437
MS 4502
Sacramento, CA 95899-7437

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: police report, health plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (patient history chart, Patient profile, Claims detail report), provider enrollment data, Confirmation of services, list items or services furnished by the provider, Pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

5) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the DHHS, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Integrated Systems of Crae Division Contract Management Unit within ten state working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;

b. E-fax at (916) 440-5287; or

c. U.S. Mail at:

Department of Health Care Services
Integrated Systems of Care Division
Attention: Contract Management Unit
P.O. Box 997437
MS 4502
Sacramento, CA 95899-7437

~~B~~**C**. Federal False Claim Act Compliance

Contractor shall comply with 42 U**.**S**.**C**.**, ~~S~~**s**ection 1396(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

27. Equal Opportunity Employer

~~In addition to Exhibit D, provision 1. Federal Equal Employment Opportunity requirements, the Contractor also agrees to the following:~~

Contractor ~~shall~~ **will**, in all solicitations or advertisements for employees placed by or on behalf of **the** Contractor, state that it is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of Contractor's commitment as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

28. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not **unlawfully** discriminate against Members or Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, **ethnic group identification**, age, sex**,** ~~or~~ physical or mental ~~handicap~~ **disability, medical condition, genetic information, gender, or gender identity,** in accordance with **section 1557 of the Patient Protection and Affordable Care Act of 2010, the Americans with Disabilities Act of 1990,** Title VI of the Civil

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Rights Act of 1964, **Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended)**; **the Age Discrimination Act of 1975**; **the Rehabilitation Act of 1973**, **as amended; the Americans with Disabilities Act of 1990, as amended, Section 11135 of the Government Code, Sections 14029.91 and 14029.92 of the Welfare and Institutions Code,** ~~(42 U.S.C. Section§ 2000d,)~~ rules and regulations promulgated pursuant thereto, or as otherwise provided by **federal or state** law or regulations. For the purpose of this Contract, discrimination **includes**, ~~s on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include,~~ but ~~are~~ is not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility~~.~~**;**

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated~~.~~;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service~~.~~**;**

4) Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any Covered Service~~.~~**; or**

5) The assignment of times or places for the provision of services on the basis of the **sex**, race, color, creed, religion, **ethnic group identification,** age, ~~sex~~ **gender**, national origin, ancestry, marital status, sexual orientation, **gender identity, physical or mental disability , medical condition, or genetic information** ~~or the physical or mental handicap~~ of the **members** to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to **sex**, race, color, creed, religion, **ethnic group identification**, ~~sex~~ **gender**, national origin, ancestry, marital status, sexual orientation, **gender identity, physical**

disability, mental disability,medical condition, or genetic information~~, or physical or mental handicap~~, except where medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes shall include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during Enrollment, re-enrollment or Disenrollment. Contractor ~~shall~~ **will** not terminate the Enrollment of an eligible individual based on an adverse change in the Member's health.

~~C. Discrimination Complaints~~

~~Contractor agrees that copies of all Grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap shall be forwarded to DHCS for review and appropriate action.~~

29. ~~Americans With Disabilities Act Of 1990~~ Additional Federal Requirements

~~This provision supplements the Americans with Disabilities Act information appearing in the Contractor Certification Clause (CCC 307).~~

Contractor shall comply with all applicable federal requirements in ~~Section 504 of the Rehabilitation Act 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12100 et seq.), Title 45, CFR, Part 84 and Title 28, CFR, Part 36~~ **Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act.**

30. Binding Arbitration

If Contractor uses binding arbitration to settle disputes, Contractor shall disclose this in all of Contractor's Marketing presentations and materials, new enrollee information, Member Enrollment Agreement Terms and Conditions, disclosure form, and any other informing materials, pursuant to the California **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14450, ~~the California~~ Health ~~and~~ **&** Safety Code, ~~S~~**s**ections 1363 and 1363.1 and the California Code of Civil Procedure~~s,~~ ~~S~~**s**ection 1295.

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at section 10115 of the Public Contract Code.

31. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "~~shall~~ **will**," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

32. Federal False Claims Act Compliance

Effective January 1, 2007, Contractor shall comply with 42USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

33. State Hearings

Contractor shall provide written position statements whenever notified by DHCS that a Member has requested a ~~S~~**s**tate hearing. Contractor also shall designate staff to make testimony at ~~S~~**s**tate hearings whenever notified by DHCS of the scheduled time and place for a ~~S~~**s**tate hearing. Contractor responsibilities regarding ~~S~~**s**tate hearings are pursuant to **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ections 10950 through 10962, and **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ections 51014.1, 51014.2, 53261 and 53452. Additional clarification of Contractor responsibilities related to ~~S~~**s**tate hearings shall be provided to Contractor by DHCS.

34. Federal Oversight Requirements

Exhibit E, Attachment 2
Program Terms and Conditions

The Contractor is considered a contractor, and not a subrecipient for the purposes of the U.S. Office of Management and Budget Uniform Guidance (Title 2 of the Code of Federal Regulations, Part 200, and, specifically, 2 CFR 200.330).

~~**33. Program Information**~~

~~Contractor shall obtain complete and current information with respect to pertinent statutes, regulations and procedure manuals affecting the operation of this Contract and Subcontracts.~~

~~**34. Compliance With Protocols**~~

~~Contractor shall develop the protocols and procedures specified in this Contract and shall comply with them within 30 days of their approval by DHCS. All subsequent revisions thereof shall be approved by DHCS and implemented by Contractor within 30 days of such approval in accordance with Title 22, CCR, Sections 53100, 53280, and 53500. Contractor shall not implement protocols, procedures or revisions thereof prior to approval by DHCS.~~

~~**35. Reimbursement and Operations Reliance**~~

~~Contractor shall not commence operations nor receive reimbursement under this Contract prior to obtaining DHCS approval of Contractor's application, including its health care delivery system, managed care organization, Marketing, and administrative systems, and execution of necessary Subcontracts for operation as a health plan.~~

Exhibit E, Attachment 3
Duties of the State

1. Payment For Services

DHCS shall pay the appropriate Capitation payments set forth in Exhibit B, Attachment 1~~, Rate of Medi-Cal Reimbursement and Exhibit B, Attachment 2, Capitation Rate Sheets,~~ to **the** Contractor for each eligible Member under this Contract, and ensure that such payments are **based on actuarially sound capitation rates defined in 42 CFR, Section 438.6(c).** ~~Such p~~**P**ayments ~~are to~~ **will** be made monthly for the duration of this Contract.

2. Medical Reviews

DHCS shall conduct medical reviews in accordance with ~~the provisions of~~ **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14456~~, and issue medical review reports to Contractor detailing findings, recommendations, and corrective action, as appropriate~~. **DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.**

3. Enrollment Processing

DHCS shall review applications for Enrollment submitted by Contractor~~,~~ **and** verify the eligibility of all applicants for Enrollment in Contractor's plan under this Contract. DHCS shall provide to Contractor a list of Members on a monthly basis.

4. Disenrollment Processing

DHCS shall review and process requests for Disenrollment. On an annual basis, provide in writing a schedule of the last calendar dates in each month by which requests for Disenrollment must be submitted to ~~the~~ DHCS by Contractor to assure that Disenrollment occurs in compliance with **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14413. DHCS may revise the schedule, as necessary, to assure that the requirements of **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14413 are met. DHCS shall provide reasonable notice to Contractor of revisions to the schedule.

Exhibit E, Attachment 3
Duties of the State

5. DHCS Approval Process

A. Within five ~~(5) State~~ working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor pursuant to Exhibit E, Attachment 2, provision 8. ~~Obtaining DHCS Approval.~~

B. Within 60 **calendar** days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to Exhibit E, Attachment 2, provision 8~~. Obtaining DHCS Approval.~~ **and** ~~P~~**p**rovide Contractor with a written explanation why its use is not approved or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 **calendar** days of receipt or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This paragraph shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 6, provision **12**~~.~~ **paragraph B**. ~~Subcontract Requirements~~, paragraph B~~, Departmental Approval~~.

6. DHCS Program Information

DHCS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 **calendar** days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHCS shall notify Contractor within 30 **calendar** days, in writing, of the reason for the delay and when Contractor may expect the information.

7. DHCS Catastrophic Coverage Limitation

DHCS shall limit Contractor's liability to provide or arrange and pay for care for illness of or injury to~~,~~ Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

DHCS **and Contractor** agree~~s~~ there shall be no risk limitation and **that** Contractor ~~shall~~ **will** have full financial liability to provide **Medically Necessary**

Exhibit E, Attachment 3
Duties of the State

Covered Services to ~~enrolled beneficiaries~~ **members as provided by the Contract and federal and state law**.

9. Notice Of Termination Of Contract

~~No later than 60 days prior to the termination or expiration of the Contract,~~ DHCS shall notify Members about their ~~medical~~ **health care** benefits and available options **upon termination or expiration of this Contract**.

10. Testing of Marketing Representatives

DHCS shall test all Contractor Marketing Representatives for knowledge of the program following completion of a comprehensive training program conducted by Contractor and prior to their engaging in Marketing or Medi-Cal Managed Care information activities on behalf of Contractor. Qualified Marketing Representatives are those persons demonstrating adequate knowledge of the program after completing the training program conducted by Contractor and passing the Medi-Cal Marketing exam administered by DHCS.

11. Policy Letters

DHCS shall provide applicable Policy Letters to Contractor as deemed necessary.

12. Review and Evaluation

Review and evaluate, relative to provider operations and costs, all reports submitted by Contractor under the provisions of Exhibit A, Attachment 17~~, Reporting Requirements~~.

Exhibit E
Additional Provisions

1. Additional Incorporated Exhibits

The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

A.	Exhibit A, Attachment 1 - Organization and Administration of the Plan	~~4 pages~~
B.	Exhibit A, Attachment 2 - Financial Information	~~4 pages~~
C.	Exhibit A, Attachment 3 - Management Information System	~~1 page~~
D.	Exhibit A, Attachment 4 - Quality Improvement System	~~13 pages~~
E.	Exhibit A, Attachment 5 - Utilization Management	~~1 page~~
F.	Exhibit A, Attachment 6 - Provider Network	~~6 pages~~
G.	Exhibit A, Attachment 7 - Provider Relations	~~3 pages~~
H.	Exhibit A, Attachment 8 - Provider Compensation Arrangements	~~4 pages~~
I.	Exhibit A, Attachment 9 - Access and Availability	~~6 pages~~
J.	Exhibit A, Attachment 10 - Scope of Services	~~8 pages~~
K.	Exhibit A, Attachment 11 - Case Management and Coordination of Care	~~2 pages~~
L.	Exhibit A, Attachment 12 – ~~This Attachment Intentionally Left Blank~~ **Local Health Department Coordination**	~~1 page~~
M.	Exhibit A, Attachment 13 - Member Services	~~6 pages~~
N.	Exhibit A, Attachment 14 - Member Grievance and Appeals	~~4 pages~~
O.	Exhibit A, Attachment 15 - Marketing	~~6 pages~~
P.	Exhibit A, Attachment 16 - Enrollments and Disenrollments	~~5 pages~~
Q.	Exhibit A, Attachment 17 - Reporting Requirements	~~3 pages~~

2. Priority of Provisions

In the event of a conflict between the provisions of Exhibit E and any other exhibit of this Contract, excluding Exhibit C, the provisions of Exhibit E shall prevail.

Exhibit X
Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

7.1 **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is

reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2021-22

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Authorize Procurement and Renewal of Insurance Policies for Policy Year (PY) 2021-22 at a premium cost not to exceed $2,950,000

Background/Discussion
CalOptima's business insurance coverage, except employee group health insurance and benefits, expires on April 7 of each year. Staff recommends renewing the same coverage categories included during PY 2020-21. As reference, the following table provides brief descriptions for the proposed insurance policies included for PY 2021-22:

Coverage Type	Description
Property	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location, not due to an Earthquake. Property, General Liability, and Commercial Auto are collectively known as Commercial Package coverage.
General Liability (GL)	Provides coverage to third parties for bodily injury or property damage.
Commercial Auto	Provides coverage for bodily injury and property damage caused by CalOptima's company-owned van, as well as collision and comprehensive coverage for the van itself. Provides excess liability for employees using personal vehicles for company business.
Workers' Compensation (WC)/ Employers Liability (EL)	Provides coverage for medical care and temporary disability benefits to employees for on-the-job injuries or illnesses.
Umbrella	Provides excess limits for general liability and commercial auto coverage over and above the respective policies.
Excess Liability	Provides excess limits over and above the Umbrella policy.
Earthquake	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location, only due to an Earthquake.
Cyber – primary and excess	Provides coverage for claims related to or arising from cyber incidents, such as a data breach (coverage includes, but is not limited to, regulatory fines and penalties, business interruption, credit monitoring, notice requirements, etc.) or network extortion (e.g., ransomware).
Directors and Officers (D&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or breach of duty by a CalOptima employee or Board member when acting within his/her official capacity.

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Coverage Type	Description
Employment Practices Liability (EPL) – primary and excess	Provides coverage for claims brought by any past, present or prospective employee against CalOptima or a CalOptima employee (acting within the scope of his/her employment) alleging, for example, employment discrimination, harassment, or wrongful termination.
Crime	Provides coverage for claims related to employee theft or forgery of money, securities, or other property, and computer and funds transfer fraud.
Managed Care Errors and Omissions (E&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or omission in the performance of CalOptima's managed care activities (e.g., provider contracting, utilization review, implementation of clinical guidelines).
Medical Malpractice (PACE)	Provides coverage for CalOptima employed physicians and certain other medical staff (i.e., CalOptima employed physician and therapists at the PACE center) in the event of a medical malpractice claim.
Pollution	Provides coverage for bodily injury, remediation expenses and property damages to third parties and remediation expenses to CalOptima in the event of a pollution incident, such as stored paint leaching into the ground water supply.
Wage and Hour – primary and excess	Provides coverage for actual or alleged violations of the Fair Labor Standards Act or any similar federal, state, or local laws governing or related to the payment of wages.
Fiduciary	Provides coverage for actual or alleged mismanagement of CalOptima's employee benefit and retirement plans.

The following table provides information on the proposed coverage limits and deductibles for each type of insurance coverage:

Coverage	Limit	Deductible
Property	Building: $65,853,951	$10,000
	Business Personal Property: $27,090,154	$10,000
	Business Interruption & Extra Expense: $36,191,896	24 Hours
GL	GL: $1,000,000/$2,000,000 Employee Benefits Liability: $1,000,000	$25,000/$1,000
Commercial Auto	Auto Liability: $1,000,000 Combined Single Limit (CSL)	$0 Liability $1,000/$1,000 Damage
WC/ EL	WC: Statutory EL: $1,000,000/$1,000,000/$1,000,000	$0 (Guaranteed Cost)
Umbrella	$25,000,000	Primary limits for GL, Commercial Auto and EL

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Coverage	Limit	Deductible
Excess Liability*	N/A	N/A
Earthquake	$75,000,000	Earthquake 5% subject to $50,000 minimum per occurrence
Cyber – primary	$10,000,000	$500,000
Cyber – excess	$10,000,000	Primary limit for Cyber
D&O/EPL – primary	$5,000,000 (Shared Limit)	$500,000/$1,000,000 Class Action
D&O/EPL – excess	$15,000,000	Primary limits for D&O/EPL
Crime	$5,000,000	$100,000
Managed Care E&O – primary	$10,000,000	$250,000/$500,000 for Breach of Contract
Managed Care E&O – excess	$10,000,000	Primary limit for Managed Care E&O
Medical Malpractice (PACE)	$1,000,000/$3,000,000	$5,000
Pollution (3-year Policy Term)	$2,000,000/$4,000,000	$25,000
Wage and Hour – primary	$5,000,000	$1,000,000
Wage and Hour - excess	$5,000,000	Primary limit for Wage and Hour
Fiduciary	$5,000,000	$25,000/$150,000 Class Action

*Please see "Explanation of significant cost increase: Umbrella and Excess Liability" for more information

On February 12, 2021, and February 17, 2021, Woodruff Sawyer, CalOptima's insurance broker, provided quotations for existing coverage. The events of 2020 (global pandemic, wildfires, civil unrest) created challenges for CalOptima's insurance broker, which resulted in potential carriers not submitting quotes to avoid additional risks, existing carriers reducing risk by increasing deductibles and decreasing limits/coverage, and all carriers covering their losses by increasing premiums. Staff has reviewed and evaluated the options. Overall, CalOptima's insurance policy renewals for PY 2021-22 are approximately 19% or $471,334 higher than the previous year. Staff recommends the following renewals at a total estimated premium not to exceed $2,950,000:

Coverage	2020-21 Premium	2021-22 Premium	$ Difference from Prior Year	% Difference from Prior Year
Renewal Premiums				
Commercial Package	$69,648	$71,108	$1,460	2%
WC/ EL	$913,151	$970,210	$57,059	6%
Umbrella	$13,622	$35,645	$22,023	162%
Excess Liability	$21,250	N/A	N/A	N/A
Earthquake	$200,322	$215,814	$15,492	8%
Cyber – primary	$110,313	$145,613	$35,300	32%

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Coverage	2020-21 Premium	2021-22 Premium	$ Difference from Prior Year	% Difference from Prior Year
Cyber – excess	$70,550	$95,865	$25,315	36%
D&O/EPL – primary, Crime**	$174,735 (D&O/EPL), $23,450 (Crime)	$209,153 (D&O/EPL) $26,376 (Crime)	$37,344	19%
D&O/EPL – excess**	$186,732	$328,525	$141,793	76%
Managed Care E&O – primary**	$247,100	$318,648	$71,548	29%
Managed Care E&O – excess**	$137,655	$186,855	$49,200	36%
Medical Malpractice (PACE)	$29,914	$32,600	$2,686	9%
Pollution (3-year Policy Term)	$5,295	$5,295	$0	0%
Wage and Hour – primary and excess	$261,725	$262,628	$903	0%
Fiduciary	$27,338	$38,549	$11,211	41%
Total: Renewal Premiums	**$2,492,800**	**$2,942,884**	**$471,334**	**19%**

**Estimated Premium; coverage still under negotiation

Due to CalOptima's use of an insurance broker and the inherent competitive quotation process, premium negotiations may often continue up to the day before policy expiration. As of February 25, 2021, the following insurance coverage policy terms are still being negotiated: D&O/EPL – primary and excess, and Managed Care E&O – primary and excess.

An explanation of significant cost increases is summarized below. A more detailed discussion from CalOptima's insurance broker on Managed Care Organization Insurance Trends is also attached to help provide context to the market trends.

- **Umbrella and Excess Liability**: CalOptima is proposing to increase the Umbrella limit from $10,000,000 to $25,000,000 and remove the $25,000,000 Excess Liability limit entirely. The Excess Liability market is hardening, and carriers do not want to cover a lot of risk. Those that are willing to cover high limits are significantly increasing premiums. CalOptima's current combined coverage limit of $35,000,000 ($10,000,000 Umbrella plus $25,000,000 Excess) is much higher than other County Organized Health System (COHS) plans. In addition, the broker's benchmarks reveal it is higher than most of the broker's clients. By increasing the Umbrella limit to $25,000,000 and removing the Excess Liability limit, CalOptima will save over $20,000.

- **Cyber**: CalOptima's primary Cyber premium increased by 32% or $35,300 from the previous year, and the deductible increased from $250,000 to $500,000, the lowest deductible that carriers are now quoting for a company the size of CalOptima. A main driver of the premium increase is the growth in Protected Health Information (PHI) and Personally Identifiable Information (PII) records, due to the year-over-year increase in membership. In general, ransomware and

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regulatory changes are driving increases in the frequency and severity of claims for carriers, resulting in increased premiums, tightening terms, and very cautious underwriting. The broker broadly marketed the primary program to fifteen (15) carriers, but no alternative insurer was able to match the breadth of coverage and competitive terms provided by the incumbent. The initial indication from the carrier was a $1,000,000 deductible; however, given the favorable responses on the renewal application and subsequent information requests, the broker was able to negotiate a $500,000 deductible and add enhanced benefits, including additional coverage for Funds Transfer Fraud and Invoice Manipulation Fraud, while keeping the premium increase below the current market average.
As the excess coverage follows the primary coverage, its market is facing the same trends. As such, the excess coverage premium similarly increased.

- **D&O/EPL – primary and excess and Crime**: CalOptima's primary D&O/EPL and Crime premium increased by 19% or $37,344 from the previous year, but the deductibles and limits remain at expiring levels. This is the most viable option for full coverage, as other carriers declined to quote or proposed higher deductibles and/or higher premiums. This is the current trend in the EPL market, particularly in California and notably in Southern California, where elevated litigation frequency and increasing severity are causing carriers to limit their risk exposure by increasing premiums, increasing retention, lowering coverage limits, or implementing a combination of these actions. In addition, litigation for EPL claims nationwide are rising as COVID-19 restrictions are lifted and companies resume and expand operations. CalOptima continues to explore the option to purchase D&O coverage only and self-insure the EPL, which would result in some premium savings.

  As the excess coverage follows the primary coverage, its market is facing the same trends. As such, the excess coverage premium similarly increased. Excess carriers are looking to shed risk, and those willing to keep it, like the incumbent carriers, are raising premiums significantly. If CalOptima decides to self-insure EPL, the excess coverage premiums will also decrease. However, staff is still in the process of evaluating the feasibility and risks involved with self-insuring EPL and recommends that CalOptima procure D&O and EPL coverage at the same expiring coverage limits. Staff will continue to work with the insurance broker to evaluate and determine whether the value received from the EPL insurance coverage is sufficient or whether self-insuring EPL might be more reasonable in light of the high deductible.

- **E&O – primary and excess**: Initially, the incumbent did not want to quote a renewal because of high claims activity on this coverage line. After discussions between the incumbent and the broker, CalOptima's primary E&O premium increased by 29% or $71,548 from the previous year, and the deductible increased from $150,000 to $250,000. In addition, the incumbent was no longer willing to cover defense costs for Breach of Contract cases, which represent the main types of cases filed against CalOptima. Very few carriers remain willing to cover Breach of Contract cases. After further discussion with the incumbent, the broker was willing to cover defense costs for Breach of Contract cases after a $500,000 deductible and subject to 50% co-insurance. If CalOptima decides to forego coverage for Breach of Contract cases, the premium savings would be approximately $22,000, representing a 20% increase over expiring premiums.

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As the excess coverage follows the primary coverage, its market is facing the same trends. As such, the excess coverage premium similarly increased. If CalOptima decides to forego coverage for Breach of Contract cases, the excess coverage premiums also will decrease. Another option for consideration is to remove the excess E&O liability entirely. CalOptima is not susceptible to normal claims, such as class action for claims denials, or inappropriate underwriting, as a public government entity. Most other COHS plans do not carry the excess coverage. The broker agrees that CalOptima could remove this coverage without much impact to risk exposure, at a premium savings of $187,000. However, staff is recommending that CalOptima procure E&O coverage, including excess coverage, at the same coverage limits, with the inclusion of the Breach of Contract cases, so that CalOptima's interests are covered while staff explores different options in the future. Staff will continue to work with the insurance broker to evaluate and determine whether the value CalOptima is receiving from the insurance coverage is suitable or whether self-insuring E&O might be more practical based on the types of claims CalOptima receives and the potential exposure to liability.

- **Fiduciary**: CalOptima's premium increased by 41% or $11,211 from the previous year, and the deductible increased from $10,000 to $25,000. This is mainly due to an increase in aggregate plan assets. Excessive litigation throughout the nation in recent years regarding plan fees have caused carriers to increase premiums to cover those case settlements.

Fiscal Impact

The fiscal impact of the annual insurance policy renewals and new coverages related to the period of April 7, 2021, through June 30, 2021, is a budgeted item under the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Management plans to include funding for insurance premiums for the remaining policy period of July 1, 2021, through April 7, 2022, and projected expenditures through fiscal year end in the CalOptima FY 2021-22 Operating Budget. As part of developing CalOptima's FY 2021-22 Operating Budget, Management will plan for and allocate budget expenditures to account for the substantial increase in deductibles.

Rationale for Recommendation

The continued procurement of business insurance, without a lapse in coverage, ensures that CalOptima's risk and exposure to claims is mitigated as much as possible.

Concurrence

Gary Crockett, Chief Counsel

Attachments

A. Contracted Entities Covered by this Recommended Board Action
B. Managed Care Organization (MCO) Insurance Trends: E&O and D&O Markets Continue to Deteriorate

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Woodruff-Sawyer & Co.	50 California Street, Floor 12	San Francisco	CA	94111
CNA	151 North Franklin St	Chicago	IL	
QBE	55 Water Street	New York	NY	10041
AWAC	199 Water St, 25th Floor	New York	NY	10038
XL	100 Constitution Plaza #15	Hartford	CT	06103
TDCSU	29 Mill Street	Unionville	CT	06085
Navigators/Hartford	83 Wooster Heights Road	Danbury	CT	06810
Ironshore	28 Liberty St, 5th Floor	New York	NY	10005
Argo Re	110 Pitts Bay Rd	Pembroke HM 08	Bermuda	
RT Specialty	180 N Stetson Ave, Ste 4600	Chicago	IL	60601
Beazley US /Lloyds	30 Batterson Park Rd	Farmington	CT	06032

INSIGHTS

Managed Care Organization (MCO) Insurance Trends: E&O and D&O Markets Continue to Deteriorate

Chad Follmer
Senior Vice President, Healthcare and Life Science Practices

FEBRUARY 4, 2021

PROPERTY & CASUALTY

The market for "signature risks" in the MCO sector—E&O, D&O, and cyber—remains hard and continues to deteriorate, with two additional carriers exits from what was already a very limited underwriting pool. The gap in carrier appetite for large plans (particularly Blue plans) versus small plans remains with the latter still being preferred, but with the new development that **all** plans are facing double-digit rate increases.

In fact, it's safe to say that it remains a very hard market for Blue plans, Delta plans, and for large public plans even by historical standards. That is saying something considering that the last hard market conditions in the early 2000s were catastrophic. This is particularly distressing for these risks as the past two renewals have also seen very steep increases. Today's increases are stacking on top of an already high starting point versus two-three years ago. If your incumbent carrier decides to non-renew or exits the industry in totality (circumstances facing an increasing number of plans), securing adequate coverage at any price can be difficult.

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While there had been ample capacity in the market up to 2018, the past two years have seen constricting capacity across the MCO / health plan universe because of pure lack of interest by the insurance community for MCO E&O and D&O.

This is due to the following developments over the past few years:

- **2018:** BCS Insurance Company exiting the MCO market. BCS stopped writing E&O and D&O insurance. Around 20% of the market's capacity disappeared overnight as a result.
- **2019:** OneBeacon Insurance Group's exit from the MCO market. OneBeacon exits from D&O and E&O and sells renewal rights to TDC Specialty Underwriters. TDC re-underwrites the OneBeacon book and only renews approximately 60% to 70% of clients.
- **2020:**
  - Allied World (AWAC) is taking a far more limited approach and is not entertaining any new business at all in certain tough venues and classes
  - AIG pulling out of the MC E&O line, cutting D&O limits and coverage while increasing retentions/premiums.
  - Chubb currently has a moratorium on all new business due to Covid uncertainties
  - Limited interest for new business across the market, as unknown liability impact of COVID.

With few case by case exceptions this leaves the following list of alternative options for new business:

- Chatham (Berkley/Travelers partner for the MC E&O)
- Ironshore
- TDC
- Berkshire: Usually excess only
- QBE: Usually excess only

These adverse developments were initially triggered by increasing "frequency of severity" and broad recognition that the industry's market has underpriced the true risks for many years.

A key driver is the mounting defense expenses and catastrophic nature of multidistrict antitrust class-action litigation against Blue Cross / Blue Shield. Most recently, COVID-19 uncertainties further impact this sector. Any appetite for new business or competition is completely absent.

YOY Rate Changes for E&O and D&O as of Q4 2020

Managed Care Errors & Omissions

Year	Rate Change	Commentary
2017	Flat	
2018	Blues: 20% to 40% All others: 5% to 10%	BCS pulls out of E&O. The severity of multidistrict litigation is becoming more evident.
2019	Blues: 25% to 75% All others: 10% to 40%	Continued clarity on the severe impact of multidistrict litigation and BCS's departure, in addition to OneBeacon's exit

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2020	All others: 25% to 60%	COVID has chilled any competition with a few carriers declining to write anything new given unknown liability. AIG has closed down MC E&O line going into 2021.

Directors & Officers Liability

Year	Rate Change	Commentary
2017	Flat: 5%	
2018	Blues: 25% to 50% All others: 5% to 10%	BCS pulls out of D&O, The severity of multidistrict litigation is becoming more evident.
2019	Blues: 25% to 100% or more All others: 10% to 45%	We see the continued impact of multidistrict litigation and BCS's departure, in addition to OneBeacon's exit.
2020	All others: 10% to 60%	Carriers cutting limits and increasing retentions with few alternative options upon marketing. In tough venues, EPL exposures further exacerbated increases and limits carrier appetites.

Principal Risks for MCOs Today

Here are some of the key risks facing MCOs in 2021.

1. **Antitrust claims effect on both E&O and D&O insurance policies.** This is when it is nice to have the same carrier for both. You won't get into a situation where two carriers are arguing about whose fault it is. However, one carrier will only defend under one policy. By having the coverage with a single carrier—while you may get your claim paid quickly—you'll usually only have one set of limits due to anti-stacking provisions.
2. **Ongoing "healthcare reform" issues:** Provider and payer services continue to blend. Health plans are creating joint ventures with health systems to more closely manage care to produce better outcomes/control costs. Provider disputes and litigation are on the rise.

   "When the rules change for HC payers and providers, we get litigation."
   –MCO E&O Teammember, Travelers Insurance

3. **Technology/privacy claims:** The landmark Anthem breach illuminated the potential scale of these claims. Current estimates put the total expected losses from that to be in the $1 billion range. So across the industry there's increased scrutiny on limit adequacy of the cyber program and also noting the knock on risks of potential carryover claims to E&O and or D&O. On that note, any remaining coverage grants for cyber as part of

the E&O are being removed. Health plans' total spend on Cyber is becoming or has already become the largest single portion of their insurance spend.

4. **Multidistrict litigation:** What started with antitrust claims against Blue Cross / Blue Shield is now spilling over into the Delta Dental sector and any other area with similarly structured cross-geography agreements.
5. **Opioid litigation carrying over:** Health plans can be sued by patients or patients' families for being an accomplice to bad provider practices re: opioid prescriptions. Meanwhile, providers can sue health plans for being kicked out of a network. These litigation trends are especially true for PBMs, but we're now seeing spill over to HMOs.
6. **Provider payment litigation:** We are seeing a sharp rise in provider litigation (especially in California). Providers are alleging underpayment, tortious interference, breach of contract, and claim statutory violations. These claims have been very costly to defend as expensive firms are often hired that quickly rack up defense expenses.
7. **EPL in the "Me Too" era:** EPL lawsuits are on the rise due to claims arising under the #MeToo movement. This is especially tough in California, with minimum retentions even for relatively small plans eclipsing $1 million, for some markets.
8. **Financial pressures on all payers:** Contrary to what many in the public may believe, payers are operating on very tight, mandated margins. These financial pressures amplify all the other sources of risk and pressure for health plans.
9. **COVID-19:** While it is far too early to tell how long this will last or how great the healthcare costs associated with this virus will be, we can say with absolute certainty that these costs will be borne largely by payers and they will be very significant. In many cases these costs / losses will pierce health plans' reinsurance (if fortunate enough to have it) and will increase the pricing in what is an already stressed reinsurance market.

Ongoing Coverage Developments in the 2021 Market Cycle

The following are some of the trends we're seeing in coverage as of Q1 2021.

- **A reintroduction of higher retentions, sublimits, and co-insurance for antitrust, regulatory, and subpoena coverage:** Carriers have begun to remove antitrust coverage regardless of exposure.
- **An overall reduction in limits capacity:** Any program with single-layer limits in excess of $10 million is being reduced to $10 million max. Many carriers are reducing the max to $5 million, going down as far as $2.5 million for D&O exposures. A $1 million maximum limit for California EPL is becoming the norm.
- **An overall increase in retention:** Depending on the state, exposure, and COVID response, carriers increasing retentions across every coverage line. A separate mass/class action retention is common.
- **Limiting D&O coverage for the entity:** Carriers have begun to limiting the entity indemnification clause to respond in securities claims only, especially in cases of bankruptcy risk.
- **An opioid exclusion is universal for PBMs:** This is also a case-by-case decision for all other types of plans depending on the insurer and the insured, however it's a sticking point with underwriters during each renewal discussion. Nobody is "giving it away." The default position is an exclusion that you may or may not be able to negotiate off.
- **Many carriers are refusing to write Blue plans altogether until multidistrict litigation is resolved:** The most severe estimates expect total limits losses for each insured and insurer on every program.

The Bottom Line

Carriers expect to see a rise in government attention with the rise in M&A and policy changes. Small pool of carriers willing to write primary E&O and D&O for healthcare entities. The larger COVID environment has dried up any interest for new business as the liability impact has yet to be fully seen.

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Underwriter scrutiny and pricing is expected to increase as healthcare entities have seen serious financial impact over the past year with some companies filing for bankruptcy particularly on the provider side.

Clients should anticipate that this market is not going to soften in the near term and should plan accordingly.

In addition to managing budgetary expectations, the MCO brokers at Woodruff are helping our clients explore captives, self-insurance, and other alternative risk vehicles as well as working with new carriers to create additional capacity and new markets.

This remains a very challenging market for MCOs with the potential for very bad outcomes for the unprepared. However, with proper preparation and experienced advisory, far more palatable outcomes are still possible.

ON-DEMAND WEBINARS

P&C Looking Ahead to 2021

Learn how much rates may go up in 2021, hear the contributing factors to rate increases, and listen in on what the underwriters are anticipating for middle markets.

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CalOptima

Better. Together.

Financial Summary

January 31, 2021

Board of Directors Meeting

March 4, 2021

Nancy Huang, Chief Financial Officer

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $4.1 million, favorable to budget $11.5 million or 154.8%
  - YTD: $14.0 million, favorable to budget $30.0 million or 187.2%
- Enrollment
  - MTD: 818,383 members, favorable to budget 12,270 or 1.5%
    - LTC unfavorable to budget 9,801 due to YTD reclassification of 10,595,members, primarily to SPD
  - YTD: 5,565,826 member months, favorable to budget 29,221 or 0.5%
- Revenue
  - MTD: $314.4 million, favorable to budget $45.4 million or 16.9% driven by Medi-Cal (MC) line of business (LOB):
    - $52.0 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to FFS from January 2021 to April 2021
    - Offset by $14.6 million due to the Bridge Period Gross Medical Expenditures (GME) and Proposition 56 risk corridor reserve
  - YTD: $2.3 billion, favorable to budget $83.8 million or 3.8% driven by MC LOB:
    - Fiscal Year (FY) 2019 hospital Directed Payments (DP) and the pharmacy benefit transition postponement
    - Offset by the Bridge Period GME and Proposition 56 risk corridor reserve

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $300.0 million, unfavorable to budget $34.5 million or 13.0%
    - Driven by MC LOB $34.3 million unfavorable variance due to pharmacy benefit transition postponement, offset by decreased utilization during COVID-19 pandemic
  - YTD: $2.2 billion, unfavorable to budget $59.4 million or 2.8%
    - Driven by MC LOB FY 2019 hospital DP and pharmacy benefit transition postponement, offset by decreased utilization during COVID-19 pandemic and Prior Year (PY) Proposition 56 Value Based Program (VBP) adjustment for a net unfavorable variance of $11.8 million
    - OCC LOB unfavorable to budget $14.7 million or 8.3%
- Administrative Expenses
  - MTD: $11.5 million, favorable to budget $0.6 million or 5.0%
  - YTD: $78.0 million, favorable to budget $10.4 million or 11.8%
- Net Investment & Other Income
  - MTD: $1.2 million, unfavorable to budget $12,167 or 1.0%
  - YTD: $3.9 million, unfavorable to budget $4.8 million or 55.1% primarily due to $5.8 million of unrealized loss on investments

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FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 95.4%, Budget 98.7%
  - YTD: Actual 96.1% (100.7% excluding DP), Budget 97.1%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.7%, Budget 4.5%
  - YTD: Actual 3.4% (3.6% excluding DP), Budget 4.0%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.92
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $103.2 million

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Enrollment Summary: January 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
125,632	111,014	14,618	13.2%	SPD	807,632	776,266	31,366	4.0%
532	471	61	13.0%	BCCTP	3,600	3,370	230	6.8%
294,733	315,805	(21,072)	(6.7%)	TANF Child	2,040,261	2,155,497	(115,236)	(5.3%)
101,989	94,917	7,072	7.5%	TANF Adult	688,606	648,250	40,356	6.2%
(6,284)	3,517	(9,801)	(278.7%)	LTC	22,955	24,577	(1,622)	(6.6%)
272,764	252,668	20,096	8.0%	MCE	1,805,766	1,734,178	71,588	4.1%
12,092	11,931	161	1.3%	WCM	80,481	83,522	(3,041)	(3.6%)
801,458	**790,323**	**11,135**	**1.4%**	**Medi-Cal Total**	**5,449,301**	**5,425,660**	**23,641**	**0.4%**
14,921	**13,975**	**946**	**6.8%**	**OneCare Connect**	**102,701**	**98,378**	**4,323**	**4.4%**
1,615	**1,378**	**237**	**17.2%**	**OneCare**	**11,118**	**9,646**	**1,472**	**15.3%**
389	**437**	**(48)**	**(11.0%)**	**PACE**	**2,706**	**2,921**	**(215)**	**(7.4%)**
818,383	**806,113**	**12,270**	**1.5%**	**CalOptima Total**	**5,565,826**	**5,536,605**	**29,221**	**0.5%**

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Financial Highlights: January 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
818,383	806,113	12,270	1.5%	Member Months	5,565,826	5,536,605	29,221	0.5%
314,384,402	268,945,186	45,439,216	16.9%	Revenues	2,283,985,839	2,200,188,817	83,797,022	3.8%
300,033,652	265,512,945	(34,520,707)	(13.0%)	Medical Expenses	2,195,970,581	2,136,579,520	(59,391,061)	(2.8%)
11,513,720	12,122,728	609,008	5.0%	Administrative Expenses	77,983,540	88,374,132	10,390,592	11.8%
2,837,029	**(8,690,487)**	**11,527,516**	**132.6%**	**Operating Margin**	**10,031,718**	**(24,764,835)**	**34,796,553**	**140.5%**
1,237,833	1,250,000	(12,167)	(1.0%)	Non Operating Income (Loss)	3,925,523	8,750,000	(4,824,477)	(55.1%)
4,074,863	**(7,440,487)**	**11,515,350**	**154.8%**	**Change in Net Assets**	**13,957,242**	**(16,014,835)**	**29,972,077**	**187.2%**
95.4%	98.7%	3.3%		Medical Loss Ratio	96.1%	97.1%	1.0%	
3.7%	4.5%	0.8%		Administrative Loss Ratio	3.4%	4.0%	0.6%	
0.9%	(3.2%)	4.1%		Operating Margin Ratio	0.4%	(1.1%)	1.6%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
95.4%	98.7%	3.3%		*MLR (excluding Directed Payments)	100.7%	97.1%	(3.6%)	
3.7%	4.5%	0.8%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

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Consolidated Performance Actual vs. Budget: January 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.1	(7.9)	12.0	Medi-Cal	7.3	(19.2)	26.5
(1.5)	(0.9)	(0.6)	OCC	(1.4)	(7.0)	5.6
(0.4)	(0.1)	(0.3)	OneCare	0.3	0.2	0.1
0.6	0.1	0.4	PACE	3.8	1.2	2.6
2.8	**(8.7)**	**11.5**	**Operating**	**10.0**	**(24.8)**	**34.8**
1.2	1.3	(0.0)	Inv./Rental Inc, MCO tax	3.9	8.8	(4.8)
1.2	**1.3**	**(0.0)**	**Non-Operating**	**3.9**	**8.8**	**(4.8)**
4.1	**(7.4)**	**11.5**	**TOTAL**	**14.0**	**(16.0)**	**30.0**

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Consolidated Revenue & Expenses: January 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	516,602	272,764	12,092	801,458	14,921	1,615	389	818,383
REVENUES								
Capitation Revenue	120,624,381	$ 135,368,316	$ 28,247,326	$ 284,240,024	$ 25,151,081	$ 1,787,704	$ 3,205,593	$ 314,384,402
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	120,624,381	135,368,316	28,247,326	284,240,024	25,151,081	1,787,704	3,205,593	314,384,402
MEDICAL EXPENSES								
Provider Capitation	35,209,961	47,322,113	9,905,723	92,437,797	10,408,718	526,584		103,373,099
Facilities	23,487,479	24,200,672	2,051,784	49,739,934	5,125,502	772,824	700,210	56,338,471
Professional Claims	22,701,905	11,040,761	835,796	34,578,463	1,064,053	90,572	480,825	36,213,913
Prescription Drugs	18,918,761	24,713,259	6,076,991	49,709,012	5,609,131	566,505	268,208	56,152,856
MLTSS	30,729,772	2,894,292	2,033,792	35,657,855	1,426,828	1,615	71,687	37,157,985
Medical Management	2,352,828	1,377,331	295,771	4,025,930	1,118,281	55,078	844,906	6,044,195
Quality Incentives	2,964,348	535,587	251,990	3,751,924	215,325		4,863	3,972,112
Reinsurance & Other	347,332	189,905	11,099	548,335	122,448		110,238	781,021
Total Medical Expenses	136,712,386	112,273,920	21,462,945	270,449,251	25,090,286	2,013,178	2,480,937	300,033,652
Medical Loss Ratio	113.3%	82.9%	76.0%	95.1%	99.8%	112.6%	77.4%	95.4%
GROSS MARGIN	**(16,088,005)**	**23,094,397**	**6,784,381**	**13,790,773**	**60,795**	**(225,475)**	**724,656**	**14,350,750**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,853,125	712,421	77,981	126,300	7,769,828
Professional fees				95,096	13,296	16,000	123	124,516
Purchased services				902,339	87,279	8,039	18,431	1,016,087
Printing & Postage				321,134	106,257	4,449	21,127	452,967
Depreciation & Amortization				282,630			2,020	284,650
Other expenses				1,536,017	875	-	1,870	1,538,762
Indirect cost allocation & Occupancy				(296,614)	599,155	42,173	(17,804)	326,911
Total Administrative Expenses				9,693,727	1,519,284	148,642	152,068	11,513,720
Admin Loss Ratio				3.4%	6.0%	8.3%	4.7%	3.7%
INCOME (LOSS) FROM OPERATIONS				4,097,046	(1,458,489)	(374,117)	572,589	2,837,029
INVESTMENT INCOME								400,019
TOTAL MCO TAX				859,277				859,277
TOTAL GRANT INCOME				(21,463)				(21,463)
CHANGE IN NET ASSETS				**$ 4,934,860**	**$ (1,458,489)**	**$ (374,117)**	**$ 572,589**	**$ 4,074,863**
BUDGETED CHANGE IN NET ASSETS				(7,908,812)	(865,554)	(57,808)	141,687	(7,440,487)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 12,843,672	$ (592,935)	$ (316,309)	$ 430,902	$ 11,515,350

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Consolidated Revenue & Expenses: January 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,563,054	1,805,766	80,481	5,449,301	102,701	11,118	2,706	5,565,826
REVENUES								
Capitation Revenue	1,066,255,110	$ 819,064,714	$ 161,962,535	$ 2,047,282,359	$ 199,944,786	$ 14,091,059	$ 22,667,636	$ 2,283,985,839
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,066,255,110	819,064,714	161,962,535	2,047,282,359	199,944,786	14,091,059	22,667,636	2,283,985,839
MEDICAL EXPENSES								
Provider Capitation	252,077,762	306,574,848	79,293,941	637,946,551	86,423,094	3,880,311		728,249,957
Facilities	165,368,837	176,132,623	17,608,011	359,109,471	33,383,263	3,610,578	4,224,865	400,328,177
Professional Claims	138,351,937	63,327,020	6,942,264	208,621,221	6,958,142	560,720	4,213,375	220,353,458
Prescription Drugs	139,475,134	174,718,752	36,185,529	350,379,416	43,706,610	4,180,570	1,999,858	400,266,453
MLTSS	238,194,053	19,878,424	13,247,244	271,319,721	10,055,474	197,911	402,057	281,975,164
Medical Management	16,508,022	9,745,687	2,070,338	28,324,047	7,640,862	259,138	6,005,849	42,229,896
Quality Incentives	8,072,982	3,582,385	455,852	12,111,219	1,519,485		118,184	13,748,888
Reinsurance & Other	59,403,084	47,588,940	85,677	107,077,701	950,192		790,695	108,818,587
Total Medical Expenses	1,017,451,811	801,548,680	155,888,856	1,974,889,348	190,637,121	12,689,229	17,754,883	2,195,970,581
Medical Loss Ratio	95.4%	97.9%	96.2%	96.5%	95.3%	90.1%	78.3%	96.1%
GROSS MARGIN	**48,803,299**	**17,516,034**	**6,073,678**	**72,393,011**	**9,307,665**	**1,401,830**	**4,912,752**	**88,015,259**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				47,704,892	4,912,287	582,976	812,465	54,012,620
Professional fees				803,567	113,562	102,012	903	1,020,044
Purchased services				5,520,995	616,224	57,262	118,150	6,312,631
Printing & Postage				1,693,246	599,133	38,969	85,733	2,417,081
Depreciation & Amortization				2,041,901			14,200	2,056,101
Other expenses				9,389,547	256,973	205	19,378	9,666,103
Indirect cost allocation & Occupancy				(2,017,257)	4,194,082	295,213	26,922	2,498,961
Total Administrative Expenses				65,136,890	10,692,260	1,076,637	1,077,753	77,983,540
Admin Loss Ratio				3.2%	5.3%	7.6%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				7,256,121	(1,384,596)	325,193	3,835,000	10,031,718
INVESTMENT INCOME								5,487,159
TOTAL MCO TAX				(1,576,001)				(1,576,001)
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				315				315
CHANGE IN NET ASSETS				**$ 5,694,485**	**$ (1,384,596)**	**$ 325,193**	**$ 3,835,000**	**$ 13,957,242**
BUDGETED CHANGE IN NET ASSETS				(19,238,432)	(6,959,052)	233,819	1,198,830	(16,014,835)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 24,932,917	$ 5,574,456	$ 91,374	$ 2,636,170	$ 29,972,077

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CalOptima
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Balance Sheet: As of January 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$641,974,864	Accounts Payable	$20,338,827
Investments	790,786,223	Medical Claims liability	1,206,240,967
Capitation receivable	317,302,480	Accrued Payroll Liabilities	16,008,366
Receivables - Other	42,818,522	Deferred Revenue	19,611,802
Prepaid expenses	7,838,325	Deferred Lease Obligations	141,492
		Capitation and Withholds	143,520,361
Total Current Assets	**1,800,720,414**	**Total Current Liabilities**	**1,405,861,816**
Capital Assets			
Furniture & Equipment	40,923,636		
Building/Leasehold Improvements	11,036,192		
505 City Parkway West	51,628,218		
	103,588,046		
Less: accumulated depreciation	(56,885,171)		
Capital assets, net	46,702,875	Other (than pensions) post employment benefits liability	26,147,377
Other Assets		Net Pension Liabilities	27,245,041
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,459,254,234**
Cash and Cash Equivalents	(291,713)		
Long-term Investments	589,128,486	**Deferred Inflows**	
Total Board-designated Assets	588,836,773	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
Total Other Assets	645,935,686	Change in Assumptions	3,728,725
		OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,493,358,975**	TNE	103,157,824
Deferred Outflows		Funds in Excess of TNE	935,930,714
Contributions	1,047,297	**TOTAL NET POSITION**	1,039,088,539
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,505,020,045**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,505,020,045**

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CalOptima A Public Agency

Board Designated Reserve and TNE Analysis: As of January 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	161,061,411				
	Tier 1 - MetLife	159,921,489				
	Tier 1 - Wells Capital	160,157,225				
Board-designated Reserve		481,140,125	325,381,543	509,041,272	155,758,582	(27,901,146)
TNE Requirement	Tier 2 - MetLife	107,696,648	103,157,824	103,157,824	4,538,823	4,538,823
	Consolidated:	**588,836,773**	**428,539,367**	**612,199,096**	**160,297,406**	**(23,362,323)**
	Current reserve level	*1.92*	*1.40*	*2.00*		

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CalOptima
A Public Agency

Our Mission

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

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CalOptima
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UNAUDITED FINANCIAL STATEMENTS

January 31, 2021

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CalOptima - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
818,383	806,113	12,270	1.5%	Member Months	5,565,826	5,536,605	29,221	0.5%
314,384,402	268,945,186	45,439,216	16.9%	Revenues	2,283,985,839	2,200,188,817	83,797,022	3.8%
300,033,652	265,512,945	(34,520,707)	(13.0%)	Medical Expenses	2,195,970,581	2,136,579,520	(59,391,061)	(2.8%)
11,513,720	12,122,728	609,008	5.0%	Administrative Expenses	77,983,540	88,374,132	10,390,592	11.8%
2,837,029	**(8,690,487)**	**11,527,516**	**132.6%**	**Operating Margin**	**10,031,718**	**(24,764,835)**	**34,796,553**	**140.5%**
1,237,833	1,250,000	(12,167)	(1.0%)	Non Operating Income (Loss)	3,925,523	8,750,000	(4,824,477)	(55.1%)
4,074,863	**(7,440,487)**	**11,515,350**	**154.8%**	**Change in Net Assets**	**13,957,242**	**(16,014,835)**	**29,972,077**	**187.2%**
95.4%	98.7%	3.3%		Medical Loss Ratio	96.1%	97.1%	1.0%	
3.7%	4.5%	0.8%		Administrative Loss Ratio	3.4%	4.0%	0.6%	
0.9%	(3.2%)	4.1%		Operating Margin Ratio	0.4%	(1.1%)	1.6%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
95.4%	98.7%	3.3%		*MLR (excluding Directed Payments)	100.7%	97.1%	(3.6%)	
3.7%	4.5%	0.8%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Seven Months Ended January 31, 2021

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	801,458	790,323	11,135	1.4%
OneCare Connect	14,921	13,975	946	6.8%
OneCare	1,615	1,378	237	17.2%
PACE	389	437	(48)	(11.0%)
Total	818,383	806,113	12,270	1.5%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 4,935	$ (7,909)	$ 12,844	162.4%
OneCare Connect	(1,458)	(866)	(592)	(68.4%)
OneCare	(374)	(58)	(316)	(544.8%)
PACE	573	142	431	303.5%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	400	1,250	(850)	(68.0%)
Total	$ 4,076	$ (7,441)	$ 11,517	154.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	95.1%	99.1%	3.9
OneCare Connect	99.8%	97.2%	(2.6)
OneCare	112.6%	95.1%	(17.5)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,694	$ 10,211	$ 518	5.1%
OneCare Connect	1,519	1,586	67	4.2%
OneCare	149	135	(14)	(10.5%)
PACE	152	191	39	20.3%
Total	$ 11,514	$ 12,123	$ 609	5.0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,081	1,161	80
OneCare Connect	192	210	18
OneCare	10	9	(0)
PACE	91	116	25
Total	1,374	1,496	122

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	741	681	61
OneCare Connect	78	67	11
OneCare	167	148	19
PACE	4	4	0
Total	990	899	91

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,449,301	5,425,660	23,641	0.4%
OneCare Connect	102,701	98,378	4,323	4.4%
OneCare	11,118	9,646	1,472	15.3%
PACE	2,706	2,921	(215)	(7.4%)
Total	5,565,826	5,536,605	29,221	0.5%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 5,694	$ (19,238)	$ 24,932	129.6%
OneCare Connect	(1,385)	(6,959)	5,574	80.1%
OneCare	325	234	91	38.9%
PACE	3,835	1,199	2,636	219.8%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	5,487	8,750	(3,263)	(37.3%)
Total	$ 13,956	$ (16,014)	$ 29,970	187.1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.5%	97.2%	0.8
OneCare Connect	95.3%	97.6%	2.3
OneCare	90.1%	89.8%	(0.2)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 65,137	$ 74,936	$ 9,799	13.1%
OneCare Connect	10,692	11,253	560	5.0%
OneCare	1,077	957	(120)	(12.5%)
PACE	1,078	1,228	151	12.3%
Total	$ 77,984	$ 88,374	$ 10,391	11.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	7,578	8,126	547
OneCare Connect	1,328	1,468	140
OneCare	70	65	(5)
PACE	636	814	177
Total	9,614	10,473	859

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	719	668	51
OneCare Connect	77	67	10
OneCare	158	148	10
PACE	4	4	1
Total	958	886	72

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended January 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	818,383		806,113		12,270	
REVENUE						
Medi-Cal	$ 284,240,024	$ 354.65	$ 238,495,003	$ 301.77	$ 45,745,021	$ 52.88
OneCare Connect	25,151,081	1,685.62	25,354,188	1,814.25	(203,107)	(128.63)
OneCare	1,787,704	1,106.94	1,565,332	1,135.94	222,372	(29.00)
PACE	3,205,593	8,240.60	3,530,663	8,079.32	(325,070)	161.28
Total Operating Revenue	314,384,402	384.15	268,945,186	333.63	45,439,216	50.52
MEDICAL EXPENSES						
Medi-Cal	270,449,251	337.45	236,192,358	298.86	(34,256,893)	(38.59)
OneCare Connect	25,090,286	1,681.54	24,633,832	1,762.71	(456,454)	81.17
OneCare	2,013,178	1,246.55	1,488,595	1,080.26	(524,583)	(166.29)
PACE	2,480,937	6,377.73	3,198,160	7,318.44	717,223	940.71
Total Medical Expenses	300,033,652	366.62	265,512,945	329.37	(34,520,707)	(37.25)
GROSS MARGIN	14,350,750	17.53	3,432,241	4.26	10,918,509	13.27
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,769,828	9.49	7,542,539	9.36	(227,289)	(0.13)
Professional fees	124,516	0.15	376,770	0.47	252,254	0.32
Purchased services	1,016,087	1.24	1,086,326	1.35	70,239	0.11
Printing & Postage	452,967	0.55	575,359	0.71	122,392	0.16
Depreciation & Amortization	284,650	0.35	460,570	0.57	175,920	0.22
Other expenses	1,538,762	1.88	1,700,422	2.11	161,660	0.23
Indirect cost allocation & Occupancy expense	326,911	0.40	380,742	0.47	53,831	0.07
Total Administrative Expenses	11,513,720	14.07	12,122,728	15.04	609,008	0.97
INCOME (LOSS) FROM OPERATIONS	2,837,029	3.47	(8,690,487)	(10.78)	11,527,516	14.25
INVESTMENT INCOME						
Interest income	790,566	0.97	1,250,000	1.55	(459,434)	(0.58)
Realized gain/(loss) on investments	443,630	0.54	-	-	443,630	0.54
Unrealized gain/(loss) on investments	(834,177)	(1.02)	-	-	(834,177)	(1.02)
Total Investment Income	400,019	0.49	1,250,000	1.55	(849,981)	(1.06)
TOTAL MCO TAX	859,277	1.05	0	-	859,277	1.05
TOTAL GRANT INCOME	(21,463)	(0.03)	-	-	(21,463)	(0.03)
CHANGE IN NET ASSETS	**4,074,863**	**4.98**	**(7,440,487)**	**(9.23)**	**11,515,350**	**14.21**
MEDICAL LOSS RATIO	**95.4%**		**98.7%**		**3.3%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.5%**		**0.8%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	5,565,826		5,536,605		29,221	
REVENUE						
Medi-Cal	$ 2,047,282,359	$ 375.70	$ 1,984,554,718	$ 365.77	$ 62,727,641	$ 9.93
OneCare Connect	199,944,786	1,946.86	180,244,489	1,832.16	19,700,297	114.70
OneCare	14,091,059	1,267.41	11,676,776	1,210.53	2,414,283	56.88
PACE	22,667,636	8,376.81	23,712,834	8,118.05	(1,045,198)	258.76
Total Operating Revenue	2,283,985,839	410.36	2,200,188,817	397.39	83,797,022	12.97
MEDICAL EXPENSES						
Medi-Cal	1,974,889,348	362.41	1,928,856,889	355.51	(46,032,459)	(6.90)
OneCare Connect	190,637,121	1,856.23	175,950,893	1,788.52	(14,686,228)	(67.71)
OneCare	12,689,229	1,141.32	10,486,151	1,087.10	(2,203,078)	(54.22)
PACE	17,754,883	6,561.30	21,285,587	7,287.09	3,530,704	725.79
Total Medical Expenses	2,195,970,581	394.55	2,136,579,520	385.90	(59,391,061)	(8.65)
GROSS MARGIN	88,015,259	15.81	63,609,297	11.49	24,405,962	4.32
ADMINISTRATIVE EXPENSES						
Salaries and benefits	54,012,620	9.70	55,204,327	9.97	1,191,707	0.27
Professional fees	1,020,044	0.18	2,600,250	0.47	1,580,206	0.29
Purchased services	6,312,631	1.13	8,782,033	1.59	2,469,402	0.46
Printing & Postage	2,417,081	0.43	4,005,013	0.72	1,587,932	0.29
Depreciation & Amortization	2,056,101	0.37	3,223,990	0.58	1,167,889	0.21
Other expenses	9,666,103	1.74	11,872,446	2.14	2,206,343	0.40
Indirect cost allocation & Occupancy expense	2,498,961	0.45	2,686,073	0.49	187,112	0.04
Total Administrative Expenses	77,983,540	14.01	88,374,132	15.96	10,390,592	1.95
INCOME (LOSS) FROM OPERATIONS	10,031,718	1.80	(24,764,835)	(4.47)	34,796,553	6.27
INVESTMENT INCOME						
Interest income	7,271,828	1.31	8,750,000	1.58	(1,478,172)	(0.27)
Realized gain/(loss) on investments	4,042,071	0.73	-	-	4,042,071	0.73
Unrealized gain/(loss) on investments	(5,826,740)	(1.05)	-	-	(5,826,740)	(1.05)
Total Investment Income	5,487,159	0.99	8,750,000	1.58	(3,262,841)	(0.59)
TOTAL MCO TAX	(1,576,001)	(0.28)	-	-	(1,576,001)	(0.28)
TOTAL GRANT INCOME	14,050	-	-	-	14,050	-
OTHER INCOME	315	-	-	-	315	-
CHANGE IN NET ASSETS	**13,957,242**	**2.51**	**(16,014,835)**	**(2.89)**	**29,972,077**	**5.40**
MEDICAL LOSS RATIO	**96.1%**		**97.1%**		**1.0%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.0%**		**0.6%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	516,602	272,764	12,092	801,458	14,921	1,615	389	818,383
REVENUES								
Capitation Revenue	120,624,381	$ 135,368,316	$ 28,247,326	$ 284,240,024	$ 25,151,081	$ 1,787,704	$ 3,205,593	$ 314,384,402
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	120,624,381	135,368,316	28,247,326	284,240,024	25,151,081	1,787,704	3,205,593	314,384,402
MEDICAL EXPENSES								
Provider Capitation	35,209,961	47,322,113	9,905,723	92,437,797	10,408,718	526,584		103,373,099
Facilities	23,487,479	24,200,672	2,051,784	49,739,934	5,125,502	772,824	700,210	56,338,471
Professional Claims	22,701,905	11,040,761	835,796	34,578,463	1,064,053	90,572	480,825	36,213,913
Prescription Drugs	18,918,761	24,713,259	6,076,991	49,709,012	5,609,131	566,505	268,208	56,152,856
MLTSS	30,729,772	2,894,292	2,033,792	35,657,855	1,426,828	1,615	71,687	37,157,985
Medical Management	2,352,828	1,377,331	295,771	4,025,930	1,118,281	55,078	844,906	6,044,195
Quality Incentives	2,964,348	535,587	251,990	3,751,924	215,325		4,863	3,972,112
Reinsurance & Other	347,332	189,905	11,099	548,335	122,448		110,238	781,021
Total Medical Expenses	136,712,386	112,273,920	21,462,945	270,449,251	25,090,286	2,013,178	2,480,937	300,033,652
Medical Loss Ratio	113.3%	82.9%	76.0%	95.1%	99.8%	112.6%	77.4%	95.4%
GROSS MARGIN	**(16,088,005)**	**23,094,397**	**6,784,381**	**13,790,773**	**60,795**	**(225,475)**	**724,656**	**14,350,750**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,853,125	712,421	77,981	126,300	7,769,828
Professional fees				95,096	13,296	16,000	123	124,516
Purchased services				902,339	87,279	8,039	18,431	1,016,087
Printing & Postage				321,134	106,257	4,449	21,127	452,967
Depreciation & Amortization				282,630			2,020	284,650
Other expenses				1,536,017	875	-	1,870	1,538,762
Indirect cost allocation & Occupancy				(296,614)	599,155	42,173	(17,804)	326,911
Total Administrative Expenses				9,693,727	1,519,284	148,642	152,068	11,513,720
Admin Loss Ratio				3.4%	6.0%	8.3%	4.7%	3.7%
INCOME (LOSS) FROM OPERATIONS				4,097,046	(1,458,489)	(374,117)	572,589	2,837,029
INVESTMENT INCOME								400,019
TOTAL MCO TAX				859,277				859,277
TOTAL GRANT INCOME				(21,463)				(21,463)
CHANGE IN NET ASSETS				**$ 4,934,860**	**$ (1,458,489)**	**$ (374,117)**	**$ 572,589**	**$ 4,074,863**
BUDGETED CHANGE IN NET ASSETS				(7,908,812)	(865,554)	(57,808)	141,687	(7,440,487)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 12,843,672	$ (592,935)	$ (316,309)	$ 430,902	$ 11,515,350

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,563,054	1,805,766	80,481	5,449,301	102,701	11,118	2,706	5,565,826
REVENUES								
Capitation Revenue	1,066,255,110	$ 819,064,714	$ 161,962,535	$ 2,047,282,359	$ 199,944,786	$ 14,091,059	$ 22,667,636	$ 2,283,985,839
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,066,255,110	819,064,714	161,962,535	2,047,282,359	199,944,786	14,091,059	22,667,636	2,283,985,839
MEDICAL EXPENSES								
Provider Capitation	252,077,762	306,574,848	79,293,941	637,946,551	86,423,094	3,880,311		728,249,957
Facilities	165,368,837	176,132,623	17,608,011	359,109,471	33,383,263	3,610,578	4,224,865	400,328,177
Professional Claims	138,351,937	63,327,020	6,942,264	208,621,221	6,958,142	560,720	4,213,375	220,353,458
Prescription Drugs	139,475,134	174,718,752	36,185,529	350,379,416	43,706,610	4,180,570	1,999,858	400,266,453
MLTSS	238,194,053	19,878,424	13,247,244	271,319,721	10,055,474	197,911	402,057	281,975,164
Medical Management	16,508,022	9,745,687	2,070,338	28,324,047	7,640,862	259,138	6,005,849	42,229,896
Quality Incentives	8,072,982	3,582,385	455,852	12,111,219	1,519,485		118,184	13,748,888
Reinsurance & Other	59,403,084	47,588,940	85,677	107,077,701	950,192		790,695	108,818,587
Total Medical Expenses	1,017,451,811	801,548,680	155,888,856	1,974,889,348	190,637,121	12,689,229	17,754,883	2,195,970,581
Medical Loss Ratio	95.4%	97.9%	96.2%	96.5%	95.3%	90.1%	78.3%	96.1%
GROSS MARGIN	**48,803,299**	**17,516,034**	**6,073,678**	**72,393,011**	**9,307,665**	**1,401,830**	**4,912,752**	**88,015,259**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				47,704,892	4,912,287	582,976	812,465	54,012,620
Professional fees				803,567	113,562	102,012	903	1,020,044
Purchased services				5,520,995	616,224	57,262	118,150	6,312,631
Printing & Postage				1,693,246	599,133	38,969	85,733	2,417,081
Depreciation & Amortization				2,041,901			14,200	2,056,101
Other expenses				9,389,547	256,973	205	19,378	9,666,103
Indirect cost allocation & Occupancy				(2,017,257)	4,194,082	295,213	26,922	2,498,961
Total Administrative Expenses				65,136,890	10,692,260	1,076,637	1,077,753	77,983,540
Admin Loss Ratio				3.2%	5.3%	7.6%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				7,256,121	(1,384,596)	325,193	3,835,000	10,031,718
INVESTMENT INCOME								5,487,159
TOTAL MCO TAX				(1,576,001)				(1,576,001)
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				315				315
CHANGE IN NET ASSETS				**$ 5,694,485**	**$ (1,384,596)**	**$ 325,193**	**$ 3,835,000**	**$ 13,957,242**
BUDGETED CHANGE IN NET ASSETS				(19,238,432)	(6,959,052)	233,819	1,198,830	(16,014,835)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 24,932,917	$ 5,574,456	$ 91,374	$ 2,636,170	$ 29,972,077

January 31, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $4.1 million, $11.5 million favorable to budget
- Operating surplus is $2.8 million, with a surplus in non-operating income of $1.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $14.0 million, $30.0 million favorable to budget
- Operating surplus is $10.0 million, with a surplus in non-operating income of $3.9 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.1	(7.9)	12.0	Medi-Cal	7.3	(19.2)	26.5
(1.5)	(0.9)	(0.6)	OCC	(1.4)	(7.0)	5.6
(0.4)	(0.1)	(0.3)	OneCare	0.3	0.2	0.1
0.6	0.1	0.4	PACE	3.8	1.2	2.6
2.8	**(8.7)**	**11.5**	**Operating**	**10.0**	**(24.8)**	**34.8**
1.2	1.3	(0.0)	Inv./Rental Inc, MCO tax	3.9	8.8	(4.8)
1.2	**1.3**	**(0.0)**	**Non-Operating**	**3.9**	**8.8**	**(4.8)**
4.1	**(7.4)**	**11.5**	**TOTAL**	**14.0**	**(16.0)**	**30.0**

CalOptima - Consolidated
Enrollment Summary
For the Seven Months Ended January 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
125,632	111,014	14,618	13.2%	SPD	807,632	776,266	31,366	4.0%
532	471	61	13.0%	BCCTP	3,600	3,370	230	6.8%
294,733	315,805	(21,072)	(6.7%)	TANF Child	2,040,261	2,155,497	(115,236)	(5.3%)
101,989	94,917	7,072	7.5%	TANF Adult	688,606	648,250	40,356	6.2%
(6,284)	3,517	(9,801)	(278.7%)	LTC	22,955	24,577	(1,622)	(6.6%)
272,764	252,668	20,096	8.0%	MCE	1,805,766	1,734,178	71,588	4.1%
12,092	11,931	161	1.3%	WCM	80,481	83,522	(3,041)	(3.6%)
801,458	**790,323**	**11,135**	**1.4%**	**Medi-Cal Total**	**5,449,301**	**5,425,660**	**23,641**	**0.4%**
14,921	**13,975**	**946**	**6.8%**	**OneCare Connect**	**102,701**	**98,378**	**4,323**	**4.4%**
1,615	**1,378**	**237**	**17.2%**	**OneCare**	**11,118**	**9,646**	**1,472**	**15.3%**
389	**437**	**(48)**	**(11.0%)**	**PACE**	**2,706**	**2,921**	**(215)**	**(7.4%)**
818,383	**806,113**	**12,270**	**1.5%**	**CalOptima Total**	**5,565,826**	**5,536,605**	**29,221**	**0.5%**
				Enrollment (by Network)				
183,212	175,511	7,701	4.4%	HMO	1,239,565	1,208,937	30,628	2.5%
222,642	228,137	(5,495)	(2.4%)	PHC	1,531,353	1,565,130	(33,777)	(2.2%)
194,024	196,248	(2,224)	(1.1%)	Shared Risk Group	1,312,980	1,332,300	(19,320)	(1.5%)
201,580	190,427	11,153	5.9%	Fee for Service	1,365,403	1,319,293	46,110	3.5%
801,458	**790,323**	**11,135**	**1.4%**	**Medi-Cal Total**	**5,449,301**	**5,425,660**	**23,641**	**0.4%**
14,921	**13,975**	**946**	**6.8%**	**OneCare Connect**	**102,701**	**98,378**	**4,323**	**4.4%**
1,615	**1,378**	**237**	**17.2%**	**OneCare**	**11,118**	**9,646**	**1,472**	**15.3%**
389	**437**	**(48)**	**(11.0%)**	**PACE**	**2,706**	**2,921**	**(215)**	**(7.4%)**
818,383	**806,113**	**12,270**	**1.5%**	**CalOptima Total**	**5,565,826**	**5,536,605**	**29,221**	**0.5%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

		Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
	HMOs															
02.SPD	SPD	10,536	10,583	10,588	10,639	10,658	10,725	11,756						75,485	72,469	3,016
03.BCC	BCCTP	1	1	1	1	1	1	1						7	7	0
05.TAN	TANF Child	54,644	55,088	55,115	55,276	55,934	56,264	56,566						388,887	405,531	(16,644)
06.TAN	TANF Adult	29,033	29,687	30,001	30,679	30,990	31,336	31,677						213,403	204,577	8,826
08.LTC	LTC	(1)	402	197	215	239	238	(1,283)						7	14	(7)
10.MCE	MCE	74,441	75,955	76,054	78,435	79,490	80,792	82,386						547,553	512,024	35,529
11.WCM	WCM	1,721	1,726	2,086	2,507	2,007	2,067	2,109						14,223	14,315	(92)
	Total	**170,375**	**173,442**	**174,042**	**177,752**	**179,319**	**181,423**	**183,212**						**1,239,565**	**1,208,937**	**30,628**
	PHCs															
02.SPD	SPD	7,145	7,205	6,855	6,760	7,010	7,042	7,103						49,120	49,156	(36)
03.BCC	BCCTP													-		0
05.TAN	TANF Child	149,810	151,008	148,874	150,336	152,122	152,428	152,751						1,057,329	1,110,109	(52,780)
06.TAN	TANF Adult	11,688	12,097	12,071	12,492	12,728	12,694	12,930						86,700	80,954	5,746
08.LTC	LTC		158	81	65	76	80	(456)						4	7	(3)
10.MCE	MCE	39,815	40,711	39,935	41,371	41,820	42,350	42,781						288,783	274,622	14,161
11.WCM	WCM	5,625	5,716	7,990	8,497	6,957	7,099	7,533						49,417	50,282	(865)
	Total	**214,083**	**216,895**	**215,806**	**219,521**	**220,713**	**221,693**	**222,642**						**1,531,353**	**1,565,130**	**(33,777)**
	Shared Risk Groups															
02.SPD	SPD	10,264	10,312	10,068	10,117	10,120	10,261	10,927						72,069	70,736	1,333
03.BCC	BCCTP													-		0
05.TAN	TANF Child	58,289	58,687	57,269	58,133	58,881	58,952	59,011						409,222	450,839	(41,617)
06.TAN	TANF Adult	28,914	29,648	29,235	30,414	30,910	31,050	31,495						211,666	206,627	5,039
08.LTC	LTC	1	365	178	209	217	219	(1,185)						4	14	(10)
10.MCE	MCE	82,747	84,907	83,063	87,432	88,969	90,268	92,357						609,743	592,235	17,508
11.WCM	WCM	924	1,000	1,954	2,189	1,382	1,408	1,419						10,276	11,849	(1,573)
	Total	**181,139**	**184,919**	**181,767**	**188,494**	**190,479**	**192,158**	**194,024**						**1,312,980**	**1,332,300**	**(19,320)**
	Fee for Service (Dual)															
02.SPD	SPD	74,615	75,198	75,269	76,815	76,628	77,616	85,109						541,250	514,710	26,540
03.BCC	BCCTP	12	17	18	18	14	14	16						109	119	(10)
05.TAN	TANF Child	1	1	1	1	1	1	1						7	16	(9)
06.TAN	TANF Adult	909	1,266	994	1,107	1,015	1,030	1,064						7,385	6,938	447
08.LTC	LTC	3,079	4,461	3,855	3,838	3,818	3,817	(2,123)						20,745	22,141	(1,396)
10.MCE	MCE	1,658	1,859	1,948	2,077	2,138	2,334	2,430						14,444	10,651	3,793
11.WCM	WCM	13	17	16	17	15	14	17						109	91	18
	Total	**80,287**	**82,819**	**82,101**	**83,873**	**83,629**	**84,826**	**86,514**						**584,049**	**554,666**	**29,383**
	Fee for Service (Non-Dual - Total)															
02.SPD	SPD	9,830	9,822	10,264	9,977	9,304	9,774	10,737						69,708	69,195	513
03.BCC	BCCTP	497	492	499	506	485	490	515						3,484	3,244	240
05.TAN	TANF Child	25,494	27,007	28,092	26,150	26,005	25,664	26,404						184,816	189,002	(4,186)
06.TAN	TANF Adult	23,028	24,014	24,847	24,196	24,229	24,315	24,823						169,452	149,154	20,298
08.LTC	LTC	351	788	580	573	560	580	(1,237)						2,195	2,401	(206)
10.MCE	MCE	45,498	47,292	52,445	48,625	49,046	49,527	52,810						345,243	344,646	597
11.WCM	WCM	791	806	974	1,076	896	899	1,014						6,456	6,985	(529)
	Total	**105,489**	**110,221**	**117,701**	**111,103**	**110,525**	**111,249**	**115,066**						**781,354**	**764,627**	**16,727**
02.SPD	SPD	112,390	113,120	113,044	114,308	113,720	115,418	125,632						807,632	776,266	31,366
03.BCC	BCCTP	510	510	518	525	500	505	532						3,600	3,370	230
05.TAN	TANF Child	288,238	291,791	289,351	289,896	292,943	293,309	294,733						2,040,261	2,155,497	(115,236)
06.TAN	TANF Adult	93,572	96,712	97,148	98,888	99,872	100,425	101,989						688,606	648,250	40,356
08.LTC	LTC	3,430	6,174	4,891	4,900	4,910	4,934	(6,284)						22,955	24,577	(1,622)
10.MCE	MCE	244,159	250,724	253,445	257,940	261,463	265,271	272,764						1,805,766	1,734,178	71,588
11.WCM	WCM	9,074	9,265	13,020	14,286	11,257	11,487	12,092						80,481	83,522	(3,041)
	Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**	**784,665**	**791,349**	**801,458**						**5,449,301**	**5,425,660**	**23,641**
	OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**	**14,587**	**14,938**	**14,921**						**102,701**	**98,378**	**4,323**
	OneCare	**1,525**	**1,523**	**1,594**	**1,627**	**1,625**	**1,609**	**1,615**						**11,118**	**9,646**	**1,472**
	PACE	**382**	**381**	**380**	**387**	**393**	**394**	**389**						**2,706**	**2,921**	**(215)**
	Grand Total	**767,745**	**784,741**	**787,920**	**797,477**	**801,270**	**808,290**	**818,383**						**5,565,826**	**5,536,605**	**29,221**

ENROLLMENT:

Overall, January enrollment was 818,383

- Favorable to budget 12,270 or 1.5%
- Increased 10,093 or 1.2% from prior month (PM) (December 2020)
- Increased 112,827 or 16.0% from prior year (PY) (January 2020)

Medi-Cal enrollment was 801,458

- Favorable to budget 11,135 or 1.4%
  - Medi-Cal Expansion (MCE) favorable 20,096
  - Seniors and Persons with Disabilities (SPD) favorable 14,618
  - Whole Child Model (WCM) favorable 161
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 61
  - Temporary Assistance for Needy Families (TANF) unfavorable 14,000
  - Long-Term Care (LTC) unfavorable 9,801 due to YTD reclassification of 10,595 members, primarily to SPD
- Increased 10,109 from PM

OneCare Connect enrollment was 14,921

- Favorable to budget 946 or 6.8%
- Decreased 17 from PM

OneCare enrollment was 1,615

- Favorable to budget 237 or 17.2%
- Increased 6 from PM

PACE enrollment was 389

- Unfavorable to budget 48 or 11.0%
- Decreased 5 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
801,458	**790,323**	**11,135**	**1.4%**	**Member Months**	**5,449,301**	**5,425,660**	**23,641**	**0.4%**
				Revenues				
284,240,024	238,495,003	45,745,021	19.2%	Capitation Revenue	2,047,282,359	1,984,554,718	62,727,641	3.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
284,240,024	**238,495,003**	**45,745,021**	**19.2%**	**Total Operating Revenue**	**2,047,282,359**	**1,984,554,718**	**62,727,641**	**3.2%**
				Medical Expenses				
96,189,722	95,641,090	(548,631)	(0.6%)	Provider Capitation	650,057,770	685,492,149	35,434,379	5.2%
49,739,934	60,292,551	10,552,617	17.5%	Facilities Claims	359,109,471	409,281,669	50,172,198	12.3%
34,578,463	34,071,886	(506,577)	(1.5%)	Professional Claims	208,621,221	231,387,750	22,766,529	9.8%
49,709,012	-	(49,709,012)	0.0%	Prescription Drugs	350,379,416	280,984,863	(69,394,553)	(24.7%)
35,657,855	41,106,001	5,448,146	13.3%	MLTSS	271,319,721	283,237,482	11,917,761	4.2%
4,025,930	4,476,824	450,894	10.1%	Medical Management	28,324,047	34,244,928	5,920,881	17.3%
548,335	604,006	55,671	9.2%	Reinsurance & Other	107,077,701	4,228,048	(102,849,653)	(2432.6%)
270,449,251	**236,192,358**	**(34,256,893)**	**(14.5%)**	**Total Medical Expenses**	**1,974,889,348**	**1,928,856,889**	**(46,032,459)**	**(2.4%)**
13,790,773	**2,302,645**	**11,488,128**	**498.9%**	**Gross Margin**	**72,393,011**	**55,697,829**	**16,695,182**	**30.0%**
				Administrative Expenses				
6,853,125	6,589,614	(263,511)	(4.0%)	Salaries, Wages & Employee Benefits	47,704,892	48,355,791	650,899	1.3%
95,096	320,521	225,425	70.3%	Professional Fees	803,567	2,206,507	1,402,940	63.6%
902,339	933,513	31,174	3.3%	Purchased Services	5,520,995	7,799,842	2,278,847	29.2%
321,134	443,433	122,299	27.6%	Printing and Postage	1,693,246	3,104,031	1,410,785	45.5%
282,630	458,500	175,870	38.4%	Depreciation & Amortization	2,041,901	3,209,500	1,167,599	36.4%
1,536,017	1,678,433	142,416	8.5%	Other Operating Expenses	9,389,547	11,726,739	2,337,193	19.9%
(296,614)	(212,557)	84,057	39.5%	Indirect Cost Allocation, Occupancy Expense	(2,017,257)	(1,466,149)	551,108	37.6%
9,693,727	**10,211,457**	**517,730**	**5.1%**	**Total Administrative Expenses**	**65,136,890**	**74,936,261**	**9,799,371**	**13.1%**
				Operating Tax				
13,328,027	15,298,995	(1,970,968)	(12.9%)	Tax Revenue	85,705,249	105,060,072	(19,354,823)	(18.4%)
12,468,750	15,298,995	2,830,245	18.5%	Premium Tax Expense	87,281,250	105,060,072	17,778,822	16.9%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
859,277	0	859,277	**0.0%**	**Total Net Operating Tax**	(1,576,001)	-	(1,576,001)	**0.0%**
				Grant Income				
(13,762)	-	(13,762)	0.0%	Grant Revenue	255,103	-	255,103	0.0%
-	-	-	0.0%	Grant expense - Service Partner	201,238	-	(201,238)	0.0%
7,700	-	(7,700)	0.0%	Grant expense - Administrative	39,816	-	(39,816)	0.0%
(21,463)	-	(21,463)	**0.0%**	**Total Grant Income**	14,050	-	14,050	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**315**	**-**	**315**	**0.0%**
4,934,860	**(7,908,812)**	**12,843,672**	**162.4%**	**Change in Net Assets**	**5,694,485**	**(19,238,432)**	**24,932,917**	**129.6%**
95.1%	***99.0%***	***3.9%***	***3.9%***	***Medical Loss Ratio***	***96.5%***	***97.2%***	***0.7%***	***0.8%***
3.4%	***4.3%***	***0.9%***	***20.3%***	***Admin Loss Ratio***	***3.2%***	***3.8%***	***0.6%***	***15.7%***

MEDI-CAL INCOME STATEMENT– JANUARY MONTH:

REVENUES of $284.2 million are favorable to budget $45.7 million driven by:

- Favorable volume related variance of $3.4 million
- Favorable price related variance of $42.4 million
  - $52.0 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to FFS from January 2021 to April 2021
  - Offset by $8.3 million of Bridge Period Gross Medical Expenditures (GME) risk corridor
  - $6.3 million of PY Proposition 56 risk corridor reserve

MEDICAL EXPENSES of $270.4 million are unfavorable to budget $34.3 million driven by:

- Unfavorable volume related variance of $3.3 million
- Unfavorable price related variance of $30.9 million
  - Prescription Drugs expense unfavorable variance of $49.7 million due to extension of the pharmacy program
  - Offset by Facilities Claims expense favorable variance of $11.4 million due to decreased utilization during COVID-19 pandemic and claims Incurred But Not Reported (IBNR)
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $6.0 million due to decreased utilization and IBNR
  - Provider Capitation expense favorable variance of $0.8 million
  - Medical Management expense favorable variance of $0.5 million

ADMINISTRATIVE EXPENSES of $9.7 million are favorable to budget $0.5 million driven by:

- Other Non-Salary expense favorable to budget $0.8 million
- Salaries & Benefit expense unfavorable to budget $0.3 million

CHANGE IN NET ASSETS is $4.9 million for the month, favorable to budget $12.8 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Seven Months Ending January 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,921	**13,975**	**946**	**6.8%**	**Member Months**	**102,701**	**98,378**	**4,323**	**4.4%**
				Revenues				
2,427,655	2,697,505	(269,850)	(10.0%)	Medi-Cal Capitation Revenue	20,852,133	18,992,101	1,860,032	9.8%
17,103,970	17,590,180	(486,210)	(2.8%)	Medicare Capitation Revenue Part C	140,014,920	124,891,314	15,123,606	12.1%
5,619,457	5,066,503	552,954	10.9%	Medicare Capitation Revenue Part D	39,077,733	36,361,074	2,716,659	7.5%
-	-	-	0.0%	Other Income	-	-	-	0.0%
25,151,081	**25,354,188**	**(203,107)**	**(0.8%)**	**Total Operating Revenue**	**199,944,786**	**180,244,489**	**19,700,297**	**10.9%**
				Medical Expenses				
10,624,043	10,769,901	145,858	1.4%	Provider Capitation	87,942,579	79,156,304	(8,786,275)	(11.1%)
5,125,502	3,966,510	(1,158,992)	(29.2%)	Facilities Claims	33,383,263	28,142,814	(5,240,449)	(18.6%)
1,064,053	967,924	(96,129)	(9.9%)	Ancillary	6,958,142	6,612,413	(345,729)	(5.2%)
1,426,828	1,537,786	110,958	7.2%	MLTSS	10,055,474	10,798,591	743,117	6.9%
5,609,131	6,029,626	420,495	7.0%	Prescription Drugs	43,706,610	41,402,981	(2,303,629)	(5.6%)
1,118,281	1,136,846	18,565	1.6%	Medical Management	7,640,862	8,309,871	669,009	8.1%
122,448	225,239	102,791	45.6%	Other Medical Expenses	950,192	1,527,919	577,727	37.8%
25,090,286	**24,633,832**	**(456,454)**	**(1.9%)**	**Total Medical Expenses**	**190,637,121**	**175,950,893**	**(14,686,228)**	**(8.3%)**
60,795	**720,356**	**(659,561)**	**(91.6%)**	**Gross Margin**	**9,307,665**	**4,293,596**	**5,014,069**	**116.8%**
				Administrative Expenses				
712,421	765,551	53,130	6.9%	Salaries, Wages & Employee Benefits	4,912,287	5,514,111	601,824	10.9%
13,296	40,083	26,787	66.8%	Professional Fees	113,562	280,581	167,019	59.5%
87,279	103,412	16,133	15.6%	Purchased Services	616,224	723,884	107,660	14.9%
106,257	106,517	260	0.2%	Printing and Postage	599,133	745,619	146,486	19.6%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
875	16,855	15,980	94.8%	Other Operating Expenses	256,973	114,009	(142,964)	(125.4%)
599,155	553,492	(45,663)	(8.2%)	Indirect Cost Allocation	4,194,082	3,874,444	(319,638)	(8.2%)
1,519,284	**1,585,910**	**66,626**	**4.2%**	**Total Administrative Expenses**	**10,692,260**	**11,252,648**	**560,388**	**5.0%**
(1,458,489)	**(865,554)**	**(592,935)**	**(68.5%)**	**Change in Net Assets**	**(1,384,596)**	**(6,959,052)**	**5,574,456**	**80.1%**
99.8%	***97.2%***	***(2.6%)***	***(2.7%)***	***Medical Loss Ratio***	***95.3%***	***97.6%***	***2.3%***	***2.3%***
6.0%	***6.3%***	***0.2%***	***3.4%***	***Admin Loss Ratio***	***5.3%***	***6.2%***	***0.9%***	***14.3%***

ONECARE CONNECT INCOME STATEMENT– JANUARY MONTH:

REVENUES of $25.2 million are unfavorable to budget $0.2 million driven by:

- Favorable volume related variance of $1.7 million
- Unfavorable price related variance of $1.9 million

MEDICAL EXPENSES of $25.1 million are unfavorable to budget $0.5 million driven by:

- Unfavorable volume related variance of $1.7 million
- Favorable price related variance of $1.2 million
  - Provider Capitation expense favorable variance of $0.9 million
  - Prescription Drugs expense favorable variance of $0.8 million
  - MLTSS expense favorable variance of $0.2 million
  - Offset by Facilities Claims expense unfavorable variance of $0.9 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($1.5) million, unfavorable to budget $0.6 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,615	**1,378**	**237**	**17.2%**	**Member Months**	**11,118**	**9,646**	**1,472**	**15.3%**
				Revenues				
1,328,041	1,078,899	249,142	23.1%	Medicare Part C revenue	9,686,214	7,967,677	1,718,537	21.6%
459,663	486,433	(26,770)	(5.5%)	Medicare Part D revenue	4,404,845	3,709,099	695,746	18.8%
1,787,704	**1,565,332**	**222,372**	**14.2%**	**Total Operating Revenue**	**14,091,059**	**11,676,776**	**2,414,283**	**20.7%**
				Medical Expenses				
526,584	426,443	(100,141)	(23.5%)	Provider Capitation	3,880,311	3,093,884	(786,427)	(25.4%)
772,824	446,141	(326,683)	(73.2%)	Inpatient	3,610,578	3,175,329	(435,249)	(13.7%)
90,572	43,685	(46,887)	(107.3%)	Ancillary	560,720	301,815	(258,905)	(85.8%)
1,615	25,895	24,280	93.8%	Skilled Nursing Facilities	197,911	179,593	(18,318)	(10.2%)
566,505	504,233	(62,272)	(12.3%)	Prescription Drugs	4,180,570	3,431,772	(748,798)	(21.8%)
55,078	42,046	(13,032)	(31.0%)	Medical Management	259,138	303,606	44,468	14.6%
-	152	152	100.0%	Other Medical Expenses	-	152	152	100.0%
2,013,178	**1,488,595**	**(524,583)**	**(35.2%)**	**Total Medical Expenses**	**12,689,229**	**10,486,151**	**(2,203,078)**	**(21.0%)**
(225,475)	**76,737**	**(302,212)**	**(393.8%)**	**Gross Margin**	**1,401,830**	**1,190,625**	**211,205**	**17.7%**
				Administrative Expenses				
77,981	64,989	(12,992)	(20.0%)	Salaries, wages & employee benefits	582,976	469,914	(113,062)	(24.1%)
16,000	16,000	-	0.0%	Professional fees	102,012	112,000	9,988	8.9%
8,039	9,750	1,711	17.6%	Purchased services	57,262	68,250	10,988	16.1%
4,449	8,084	3,635	45.0%	Printing and postage	38,969	56,588	17,619	31.1%
-	537	537	100.0%	Other operating expenses	205	3,759	3,554	94.5%
42,173	35,185	(6,988)	(19.9%)	Indirect cost allocation, occupancy expens	295,213	246,295	(48,918)	(19.9%)
148,642	**134,545**	**(14,097)**	**(10.5%)**	**Total Administrative Expenses**	**1,076,637**	**956,806**	**(119,831)**	**(12.5%)**
(374,117)	**(57,808)**	**(316,309)**	**(547.2%)**	**Change in Net Assets**	**325,193**	**233,819**	**91,374**	**39.1%**
112.6%	***95.1%***	***(17.5%)***	***(18.4%)***	***Medical Loss Ratio***	***90.1%***	***89.8%***	***(0.2%)***	***(0.3%)***
8.3%	***8.6%***	***0.3%***	***3.3%***	***Admin Loss Ratio***	***7.6%***	***8.2%***	***0.6%***	***6.8%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
389	**437**	**(48)**	**(11.0%)**	**Member Months**	**2,706**	**2,921**	**(215)**	**-7.4%**
				Revenues				
2,447,373	2,752,875	(305,502)	(11.1%)	Medi-Cal Capitation Revenue	17,028,687	18,390,737	(1,362,050)	(7.4%)
603,064	624,306	(21,242)	(3.4%)	Medicare Part C Revenue	4,431,234	4,284,422	146,812	3.4%
155,156	153,482	1,674	1.1%	Medicare Part D Revenue	1,207,714	1,037,675	170,039	16.4%
3,205,593	**3,530,663**	**(325,070)**	**(9.2%)**	**Total Operating Revenue**	**22,667,636**	**23,712,834**	**(1,045,198)**	**(4.4%)**
				Medical Expenses				
844,906	959,329	114,423	11.9%	Medical Management	6,005,849	6,711,348	705,499	10.5%
700,210	865,745	165,535	19.1%	Facilities Claims	4,224,865	5,604,141	1,379,276	24.6%
480,825	716,751	235,926	32.9%	Professional Claims	4,213,375	4,688,010	474,635	10.1%
110,238	272,240	162,002	59.5%	Patient Transportation	790,695	1,778,726	988,031	55.5%
268,208	293,298	25,090	8.6%	Prescription Drugs	1,999,858	1,927,865	(71,993)	(3.7%)
71,687	71,139	(548)	(0.8%)	MLTSS	402,057	445,307	43,250	9.7%
4,863	19,658	14,796	75.3%	Other Expenses	118,184	130,190	12,006	9.2%
2,480,937	**3,198,160**	**717,223**	**22.4%**	**Total Medical Expenses**	**17,754,883**	**21,285,587**	**3,530,704**	**16.6%**
724,656	**332,503**	**392,153**	**117.9%**	**Gross Margin**	**4,912,752**	**2,427,247**	**2,485,505**	**102.4%**
				Administrative Expenses				
126,300	122,385	(3,915)	(3.2%)	Salaries, wages & employee benefits	812,465	864,511	52,046	6.0%
123	166	43	25.7%	Professional fees	903	1,162	259	22.3%
18,431	39,651	21,220	53.5%	Purchased services	118,150	190,057	71,907	37.8%
21,127	17,325	(3,802)	(21.9%)	Printing and postage	85,733	98,775	13,042	13.2%
2,020	2,070	50	2.4%	Depreciation & amortization	14,200	14,490	290	2.0%
1,870	4,597	2,727	59.3%	Other operating expenses	19,378	27,939	8,561	30.6%
(17,804)	4,622	22,426	485.2%	Indirect Cost Allocation, Occupancy Expense	26,922	31,483	4,561	14.5%
152,068	**190,816**	**38,748**	**20.3%**	**Total Administrative Expenses**	**1,077,753**	**1,228,417**	**150,664**	**12.3%**
				Operating Tax				
5,773	-	5,773	0.0%	Tax Revenue	40,157	-	40,157	0.0%
5,773	-	(5,773)	0.0%	Premium Tax Expense	40,157	-	(40,157)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
572,589	**141,687**	**430,902**	**304.1%**	**Change in Net Assets**	**3,835,000**	**1,198,830**	**2,636,170**	**219.9%**
77.4%	***90.6%***	***13.2%***	***14.6%***	***Medical Loss Ratio***	***78.3%***	***89.8%***	***11.4%***	***12.7%***
4.7%	***5.4%***	***0.7%***	***12.2%***	***Admin Loss Ratio***	***4.8%***	***5.2%***	***0.4%***	***8.2%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
36,275	55,000	18,725	34.0%	Purchase services	274,810	385,000	110,190	28.6%
168,178	177,250	9,072	5.1%	Depreciation & amortization	1,194,370	1,240,750	46,380	3.7%
18,423	18,500	77	0.4%	Insurance expense	128,959	129,500	541	0.4%
126,266	114,917	(11,349)	(9.9%)	Repair and maintenance	751,190	804,417	53,227	6.6%
26,402	41,250	14,848	36.0%	Other Operating Expense	350,466	288,750	(61,716)	(21.4%)
(375,545)	(406,917)	(31,372)	(7.7%)	Indirect allocation, Occupancy	(2,699,794)	(2,848,417)	(148,623)	(5.2%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – JANUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.4) million, unfavorable to budget 0.3 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million, favorable to budget $0.4 million

CalOptima
Balance Sheet
January 31, 2021

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$641,974,864		Accounts Payable	$20,338,827
	Investments	790,786,223		Medical Claims liability	1,206,240,967
	Capitation receivable	317,302,480		Accrued Payroll Liabilities	16,008,366
	Receivables - Other	42,818,522		Deferred Revenue	19,611,802
	Prepaid expenses	7,838,325		Deferred Lease Obligations	141,492
				Capitation and Withholds	143,520,361
	Total Current Assets	**1,800,720,414**		**Total Current Liabilities**	**1,405,861,816**
Capital Assets					
	Furniture & Equipment	40,923,636			
	Building/Leasehold Improvements	11,036,192			
	505 City Parkway West	51,628,218			
		103,588,046			
	Less: accumulated depreciation	(56,885,171)			
	Capital assets, net	46,702,875	Other (than pensions) post		
				employment benefits liability	26,147,377
Other Assets			Net Pension Liabilities		27,245,041
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	56,798,913			
	Board-designated assets:			**TOTAL LIABILITIES**	**1,459,254,234**
	Cash and Cash Equivalents	(291,713)			
	Long-term Investments	589,128,486	Deferred Inflows		
	Total Board-designated Assets	588,836,773		Excess Earnings	506,547
				OPEB 75 Difference in Experience	804,000
	Total Other Assets	645,935,686		Change in Assumptions	3,728,725
				OPEB Changes in Assumptions	1,638,000
			Net Position		
TOTAL ASSETS		**2,493,358,975**		TNE	103,157,824
				Funds in Excess of TNE	935,930,714
Deferred Outflows			**TOTAL NET POSITION**		1,039,088,539
	Contributions	1,047,297			
	Difference in Experience	4,280,308			
	Excess Earning	-			
	Changes in Assumptions	5,060,465			
	OPEB 75 Changes in Assumptions	703,000			
	Pension Contributions	570,000			
	TOTAL ASSETS & DEFERRED OUTFLOWS	**2,505,020,045**		**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,505,020,045**

CalOptima
Board Designated Reserve and TNE Analysis
as of January 31, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	161,061,411				
	Tier 1 - MetLife	159,921,489				
	Tier 1 - Wells Capital	160,157,225				
Board-designated Reserve		481,140,125	325,381,543	509,041,272	155,758,582	(27,901,146)
TNE Requirement	Tier 2 - MetLife	107,696,648	103,157,824	103,157,824	4,538,823	4,538,823
	Consolidated:	**588,836,773**	**428,539,367**	**612,199,096**	**160,297,406**	**(23,362,323)**
	Current reserve level	*1.92*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
January 31, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	4,074,863	13,957,242
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	452,828	3,250,471
Changes in assets and liabilities:		
Prepaid expenses and other	(948,886)	(1,139,117)
Catastrophic reserves		
Capitation receivable	34,678,314	86,249,023
Medical claims liability	230,692,560	289,088,947
Deferred revenue	4,747	(3,811,894)
Payable to health networks	5,033,126	539,333
Accounts payable	(24,731,908)	(54,317,618)
Accrued payroll	1,132,871	2,832,033
Other accrued liabilities	(2,789)	(19,365)
Net cash provided by/(used in) operating activities	250,385,727	336,629,055
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	(18,803,577)	(66,599,911)
Change in Property and Equipment	23,432	(3,298,776)
Change in Board designated reserves	(257,239)	(3,952,880)
Change in Homeless Health Reserve	400,000	400,000
Net cash provided by/(used in) investing activities	(18,637,385)	(73,451,566)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	231,748,342	263,177,490
CASH AND CASH EQUIVALENTS, beginning of period	$410,226,522	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**641,974,864**	**641,974,864**

BALANCE SHEET– JANUARY MONTH:

ASSETS of $2.5 billion increased $216.2 million from December or 9.4%

- Operating Cash increased $231.7 million due to Hospital Quality Assurance Fee (HQAF) funding received, which will be disbursed in February
- Investments increased $18.8 million due to the timing of cash receipts and month-end requirements for operating cash
- Capitation Receivables decreased $37.2 million due to the timing of cash receipts and disbursements

LIABILITIES of $1.5 billion increased $212.1 million from December or 17.0%

- Claims Liabilities increased $230.7 million due to timing of claim payments, changes in IBNR, and HQAF funding to be paid out
- Capitation and Withhold increased $5.0 million due to timing of capitation payments
- Accounts Payable decreased $24.7 million due to payment of Managed Care Organization (MCO) tax

NET ASSETS of $1.0 billion, increased $4.1 million from December or 0.4%

Summary of Homeless Health Initiatives and Allocated Funds
As of January 31, 2021

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for January 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	2021
November	Medi-Cal	Business Integration - Temporary Help	Process Excellence - Temporary Help	$43,000	To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst.	2021
January	Medi-Cal	Provider Relations - Printing	Sales & Marketing - Member Communication	$10,000	To reallocate funds from Public Relations - Printing to cover shortage in Sales & Marketing - Member Communications.	2021

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
March 4, 2021

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- 2021 PACE and Medicare Parts C and D Program Audits (*applicable to OneCare, OneCare Connect and PACE*):

  On December 23, 2020, the Centers for Medicare & Medicaid Services (CMS) outlined how it will proceed with PACE and Medicare Parts C and D program audit activities in light of the ongoing public health emergency. CMS expects to proceed with program audits in calendar year 2021 and will send audit engagement letters to organizations from mid-March through September 2021 on a rolling basis. CMS will provide the same flexibilities in 2021 that were granted to audited organizations in 2020. The flexibilities include additional time to provide requested documentation, respond to questions, respond to the draft audit report, implement corrective actions, and demonstrate the correction of findings. CalOptima's Office of Compliance continues to prepare impacted stakeholders for these anticipated audits.

- 2021 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2021. The validation audit is expected to take place starting in March and conclude in June 2021. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations

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- Medicare Therapy Management (MTM) Program
- Special Needs Plan (SNP) Care Management
- Improving Drug Utilization Review (IDUR) Controls

CalOptima departments are working to review the reported data for each area for regulatory submissions by the CMS submission deadlines of February 1, 2021 and February 22, 2021.

- 2021 Timeliness Monitoring Project (TMP):

  On September 18, 2020, CMS announced it will conduct the industry wide Timeliness Monitoring Project (TMP) starting in January 2021. CMS will collect data for organization determinations, and appeals and grievances (ODAG) to assess timeliness in processing Medicare Advantage (Part C) reconsiderations, as well as compliance with forwarding cases to the independent review entity (IRE). Findings may result in compliance actions, if necessary, and may have implications for the Star Ratings. On January 11, 2021, CMS formally engaged CalOptima's OneCare program for the TMP. The ODAG universes and supporting documentation were submitted to CMS on January 21, 2021, and the validation webinar was held on February 1, 2021.

- Contract Year (CY) 2019 Medicare Part D Improper Payment Measure (Part D IPM) (OneCare and OneCare Connect):

  On January 15, 2021, CMS informed CalOptima that its OneCare and OneCare Connect contracts have been selected to participate in the CY 2019 Medicare Part D Improper Payment Measure (Part D IPM) audit, formerly known as the Payment Error Related to Prescription Drug Event Validation (PEPV). CMS conducts the Part D IPM audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2019 payments. On January 29, 2021, CMS held an IMP training teleconference to discuss the audit process.

2. OneCare Connect

- Performance Measure Validation (PMV) for Medicare-Medicaid Plans (MMPs):

  By way of background, CMS requires MMPs to report various monitoring and performance measures, as outlined in the MMP Core Reporting Requirements and MMP State-Specific Reporting Requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures.

  On July 8, 2020, CMS' contractor, HSAG/NORC, notified CalOptima of its selection for validation of two (2) performance measures for its OneCare Connect program:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
  - MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

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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On September 15, 2020, CMS conducted the validation audit by webinar. On December 21, 2020, HSAG/NORC issued preliminary results, which indicated that measure data were compliant with CMS' specifications and the data, as reported, were valid for both performance measures. On January 15, 2021, HSAG/NORC provided the final report, which confirmed that CalOptima was compliant for the two (2) performance measures and data, as reported, were considered valid.

3. PACE

- 2019 CMS Financial Audit:

On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from CalOptima that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

On December 4, 2020, Myers & Stauffer notified CalOptima of the selection of the prescription drug event (PDE) samples and associated documentation request. CalOptima submitted the full set of requested PDE samples to Myers & Stauffer ahead of the 2/2/21 deadline.

4. Medi-Cal

- 2020 DHCS Medical Audit:

The 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 August 11, 2020, the DHCS provided CalOptima with a final audit report and a formal request for a corrective action plan (CAP). The report identified seven (7) Medi-Cal findings in the audit areas of Access and Availability of Care and Member's Rights. CalOptima did not receive any findings for State Supported Services or the Cal MediConnect program. CalOptima submitted a timely CAP to the DHCS by the deadline of September 11, 2020.

As part of the CAP process, CalOptima provided monthly updates to the DHCS in October, November, and December 2020. On January 19, 2021, the DHCS confirmed the closure of CalOptima's CAP. The 2020 DHCS Medical Audit is considered closed with no additional action required.

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B. Regulatory Notices of Non-Compliance

- On January 15, 2021, CMS issued warning letters to CalOptima's OneCare and OneCare Connect programs for failing to meet contract year 2021 Part D formulary requirements. CalOptima has completed its review of the deficiencies cited by CMS and contested the findings on January 21, 2021. CalOptima is pending a response from CMS.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of October 2020 – December 2020 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for six (6) consecutive months for Medi-Cal expedited appeals and for four (4) consecutive months for Medi-Cal standard appeals.

Month	Compliance Goal	Expedited Appeals Resolved within ≤ 72 Hours of Receipt
October 2020	98%	75%
November 2020	98%	80%
December 2020	98%	50%

Month	Compliance Goal	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt
October 2020	98%	67%
November 2020	98%	55%
December 2020	98%	78%

- CalOptima's Audit & Oversight (A&O) department escalated the CAP that was previously issued to an immediate corrective action plan (ICAP) as issues with non-timely processing of Medi-Cal appeals have extended to both expedited and standard appeals and appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard and expedited appeals.

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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2. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
October 2020	100%	100%	95%	0%	0%
November 2020	100%	100%	100%	30%	0%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Based on a focused review of ten (10) Medi-Cal standard appeals for November 2020, seven (7) files exceeded the sixth (6th) grade reading level resulting in a low compliance score of 30% for member notice content.

  - Based on a focused review of ten (10) Medi-Cal standard appeals for November 2020, all ten (10) files did not meet the timeframe for processing a standard appeal resulting in a low compliance score of 0% for resolution timeliness.

  - As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals Resolved within 72 Hours of Receipt
October 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2020	100%	100%	100%	10%	80%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Based on a focused review of ten (10) Medi-Cal expedited appeals for November 2020, the lower compliance score of 10% for member notice content was due to nine (9) files exceeding the 6th grade reading level.

  - Based on a focused review of ten (10) Medi-Cal expedited appeals for November 2020, the lower compliance score of 80% for expedited appeals resolved within 72 hours of

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receipt was due to two (2) files not meeting the timeframe for processing an expedited appeal.

- As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal expedited appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited appeals.

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances Resolved within ≤ 30 Calendar Days of Receipt
October 2020	100%	100%	94.44%	77.77%	100%
November 2020	100%	100%	100%	100%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
October 2020	100%	100%	100%	75%	100%
November 2020	100%	100%	100%	100%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS

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department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2020	100%	100%	100%	100%	100%	100%	100%
November 2020	100%	75%	83%	100%	100%	100%	75%
December 2020	90.9	90.9%	100%	90.9%	90.9%	100%	100%

- Based on a focused review of twelve (12) Medi-Cal prior authorizations for November 2020, the lower compliance score of 75% was due to untimely resolution of three (3) standard prior authorizations.

- Based on a focused review of twelve (12) Medi-Cal prior authorizations for November 2020, the lower compliance score of 83% was due to two (2) standard prior authorizations lacking evidence of member notifications.

- Based on a focused review of twelve (12) Medi-Cal prior authorizations for November 2020, the lower compliance score of 75% was due to three (3) standard prior authorization member letters exceeding the 6th grade reading level.

- Based on a focused review of eleven (11) Medi-Cal prior authorizations for December 2020, the lower compliance score of 90.9% was due to one (1) file misclassified as a modified prior authorization instead of a denial.

- Based on a focused review of eleven (11) Medi-Cal prior authorizations for December 2020, the lower compliance score of 90.9% was due to untimely resolution of one (1) standard prior authorization.

- Based on a focused review of eleven (11) Medi-Cal prior authorizations for December 2020, the lower compliance score of 90.9% for clinical decision making review was due to one (1) file not following clinical hierarchy guidelines.

- Based on a focused review of eleven (11) Medi-Cal prior authorizations for December 2020, the lower compliance score of 90.9% was due to one (1) file not being processed accurately.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard Medi-Cal prior authorizations. The A&O department continues to work with the

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Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard prior authorizations.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2020	100%	80%	100%	90%	100%	100%	100%
November 2020	100%	50%	100%	100%	88%	100%	100%
December 2020	100%	90%	100%	90%	100%	100%	100%

- Based on a focused review of eight (8) Medi-Cal urgent prior authorizations for November 2020, the lower compliance score of 50% was due to untimely resolution of four (4) urgent prior authorizations.

- Based on a focused review of eight (8) Medi-Cal urgent prior authorizations for November 2020, the lower compliance score of 88% was due to not following the appropriate processing requirements for denials for one (1) urgent prior authorization.

- Based on a focused review of ten (10) Medi-Cal urgent prior authorizations for December 2020, the lower compliance score of 90% was due to untimely resolution of one (1) urgent prior authorization.

- Based on a focused review of ten (10) Medi-Cal urgent prior authorizations for December 2020, the lower compliance score of 90% was due to one (1) file being closed too early without verifying tried and failed medications prior to the turnaround time deadline.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of urgent Medi-Cal prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of urgent prior authorizations.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
October 2020	100%	100%	100%	0%	100%
November 2020	100%	100%	100%	0%	0%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Based on a focused review of two (2) OneCare standard appeals for November 2020, the lower compliance score of 0% for member notice content was due to two (2) files exceeding the 6th grade reading level and the acknowledgement and resolution letters not including an updated non-discrimination notice.

- Based on a focused review of two (2) OneCare standard appeals for November 2020, the lower compliance score of 0% was due to untimely resolution of two (2) standard appeals.

- As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals.

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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- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
October 2020	100%	100%	100%	50%	100%
November 2020	100%	100%	100%	0%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Based on a focused review of six (6) OneCare standard grievances for November 2020, the lower compliance score of 0% for member notice content was due to all six (6) files exceeding the 6th grade reading level.

  - As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard grievances.

- OneCare Utilization Management: Standard Pre-Service Organization Determinations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2020	100%	100%	100%	100%	100%	100%	100%
November 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
December 2020	100%	100%	100%	100%	100%	100%	66.6%

  - There are no significant updates to provide for the file review of OneCare standard pre-service organization determinations for the months of October and November 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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- Based on a focused review of three (3) OneCare standard pre-service organization determinations for December 2020, the lower compliance score of 66.6% for member notice content was due to the notification letter not including an updated non-discrimination notice for one (1) standard pre-service organization determination.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard pre-service organization determinations. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard pre-service organization determinations.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
October 2020	100%	100%	100%	25%	66.67%
November 2020	100%	100%	100%	0%	85.71%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Based on a focused review of seven (7) OneCare Connect standard appeals for November 2020, the lower compliance score of 0% for member notice content was due to all seven (7) files exceeding the 6th grade reading level.

- Based on a focused review of seven (7) OneCare Connect standard appeals for November 2020, the lower compliance score of 85.71% was due to untimely resolution of one (1) standard appeal.

- As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals.

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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- OneCare Connect GARS: Expedited Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Expedited Verbally Acknowledged within ≤ 24 Hours of Receipt
October 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2020	100%	100%	100%	0%	N/A
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Based on a focused review of one (1) OneCare Connect expedited appeal for November 2020, the lower compliance score of 0% for member notice content was due to one (1) file exceeding the 6th grade reading level and the resolution letter not including the updated non-discrimination notice.

  - As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect expedited appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited appeals.

- OneCare Connect GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved within ≤ 30 Calendar Days of Receipt
October 2020	100%	100%	100%	80%	100%
November 2020	100%	100%	100%	0%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Based on a focused review of fifteen (15) OneCare Connect standard grievances for November 2020, the lower compliance score of 0% for member notice content was due to the resolution letters not including an updated non-discrimination notice insert for all fifteen (15) files.

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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- As a result of the ICAP issued to the GARS department on December 15, 2020, CalOptima's Audit & Oversight department increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities in lieu of its routine monthly monitoring.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard grievances.

- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2020	100%	100%	90%	90%	100%	90%	100%
November 2020	100%	100%	90%	100%	100%	80%	0%
December 2020	100%	100%	90%	100%	100%	80%	40%

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for November 2020, the lower compliance score of 90% for provider and member notification timeliness was due to the fax notification exceeding the 24-hour notification turnaround time for one (1) file.

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for November 2020, the lower compliance score of 80% was due to two (2) denial letters not being fully translated in the member's preferred language (Spanish).

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for November 2020, the lower compliance score of 0% for member notice content was due to the notification letter not including an updated non-discrimination notice for all ten (10) standard prior authorizations.

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for December 2020, the lower compliance score of 90% was due to untimely resolution of one (1) standard prior authorization.

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for December 2020, the lower compliance score of 80% was due to two (2) denial letters not being fully translated in the member's preferred language (Spanish).

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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- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for December 2020, the lower compliance score of 40% for member notice content was due to the notification letter not including an updated non-discrimination notice for six (6) standard prior authorizations.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard prior authorizations.

- OneCare Connect Utilization Management: Expedited Service Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2020	100%	70%	90%	80%	100%	100%	100%
November 2020	100%	60%	90%	100%	100%	80%	0%
December 2020	100%	50%	70%	80%	100%	100%	10%

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for November 2020, the lower compliance score of 60% for resolution timeliness was due to the decision made exceeding the required timeframe for four (4) expedited service authorizations.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for November 2020, the lower compliance score of 90% for provider and member notification timeliness was due to the first telephonic outreach to the member exceeding the 72-hour timeframe for one (1) expedited service authorization.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for November 2020, the lower compliance score of 80% was due to member notification letters not written in the members' preferred language in two (2) expedited service authorizations.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for November 2020, the lower compliance score of 0% for member notice content was due to the notification letter not including an updated non-discrimination notice for all ten (10) expedited service authorizations.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for December 2020, the lower compliance score of 50% for resolution

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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timeliness was due to the decision made exceeding the required timeframe for five (5) expedited service authorizations.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for December 2020, the lower compliance score of 70% for provider and member notification timeliness was due to the first telephonic outreach to the member exceeding the 72-hour timeframe for three (3) expedited service authorizations.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for December 2020, the lower compliance score of 80% for clinical decision making review was due to two (2) files not following clinical hierarchy guidelines.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for December 2020, the lower compliance score of 10% for member notice content was due to the notification letter not including an updated non-discrimination notice for nine (9) expedited service authorizations.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of expedited OneCare Connect service authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited service authorizations.

5. Internal Audits: [a\]

- 2020 Medicare Part C Organization Determinations, Appeals and Grievances (ODAG) Program and Medicare-Medicaid Plan (MMP) Service Authorization Requests, Appeals and Grievances (SARAG) Internal Audit

  - During the third quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Medicare Part C Organization Determinations, Appeals and Grievances (ODAG) for its OneCare program and Medicare-Medicaid Plan (MMP) Service Authorization Requests, Appeals and Grievances (SARAG) for its OneCare Connect program to ensure compliance with universe, timeliness, clinical decision making, and processing requirements for the review period of April 1, 2020 - June 30, 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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- Part C Organization Determinations, Appeals and Grievances (ODAG) - File Review

Measures	Files Reviewed	Compliance Score
Standard Pre-Service Organization Determinations – Utilization Management		
File Classification	7	100%
Resolution Timeliness	7	100%
Provider and Member Notification Timeliness	7	85.71%
Clinical Decision Making	7	57%
Accuracy	7	100%
Written Response in Member's Preferred Language	7	100%
Accuracy of Member Notification	7	100%

- Based on a focused review of seven (7) OneCare Standard Pre-Service Organization Determinations (ODAG-1) for April 2020 – June 2020, the lower compliance score of 85.71 % was due to one (1) file not following the provider notification process.

- Based on a focused review of seven (7) OneCare Standard Pre-Service Organization Determinations (ODAG-1) for April 2020 – June 2020, the lower compliance score of 57% for clinical decision making review was due to three (3) files not following clinical hierarchy guidelines.

Measures	Files Reviewed	Compliance Score
Expedited Pre-Service Organization Determinations - Pharmacy		
Clinical Decision Making Accuracy & Processing Requirements	1	0%
Decision Making/Notification Timeliness	1	100%

- Based on a focused review of one (1) OneCare Expedited Pre-Service Organization Determination (EOD) for clinical decision making for April 2020 – June 2020, the lower compliance score of 0% was due to one (1) file exceeding the 6th grade reading level.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Measures	Files Reviewed	Compliance Score
Requests for Payment Organization Determinations (Claims) - Denied		
Acknowledgement Timeliness	5	100%
Processing Accuracy	5	100%
Resolution Timeliness	5	100%
Interest Accuracy	5	100%
Check Clearing Timeliness	N/A	N/A

Measures	Files Reviewed	Compliance Score
Direct Member Reimbursement		
Processing Requirements	1	0%

- Based on a focused review of one (1) Direct Member Reimbursement (DMR) for Customer Service (OneCare) from April 2020 - June 2020, the lower compliance score of 0% was due to the lack of notification that the member's reimbursement was approved.

Measures	Files Reviewed	Compliance Score
Standard Pre-Service Reconsiderations		
Classification Score	3	100%
Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	3	100%
Language Preference	3	100%
Clinical Decision Making	3	100%
Member Notice Content	0	0%
Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt	3	100%

- Based on a focused review of three (3) OneCare Standard Pre-Service Reconsiderations (SREC) from April 2020 – June 2020, the lower compliance score of 0% for member notice content was due to three (3) files exceeding the 6th grade reading level.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Measures	Files Reviewed	Compliance Score
OneCare Payment Reconsiderations		
Classification Score	1	100%
Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	1	100%
Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt or 72 Hours Urgent	1	100%

Measures	Files Reviewed	Compliance Score
Dismissals		
Classification Score	2	100%
Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	2	50%
Resolution of Appeals Resolved ≤ 60 Calendar Days of Receipt	2	50%

- Based on a focused review of two (2) dismissals from April 2020 – June 2020, the lower compliance score of 50% was due to one (1) untimely acknowledgement of a standard appeal. The lower compliance score of 50% for resolution of appeals was due to one (1) file exceeding the resolution timeframe.

Measures	Files Reviewed	Compliance Score
Written Standard Grievances		
Classification Score	4	100%
Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	4	100%
Language Preference	4	100%
Member Notice Content	4	25%
Resolution of Grievance Resolved ≤ 30 Calendar Days of Receipt	4	100%

- Based on a focused review of four (4) OneCare standard grievances from April 2020 – June 2020, the lower compliance score of 25% was due to three (3) files not meeting notice requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medicare-Medicaid Plan (MMP) Service Authorization Requests, Appeals and Grievances (SARAG) File Review

Measures	Files Reviewed	Compliance Score
MMP Standard Service Authorization Requests - Utilization Management		
File Classification	3	100%
Resolution Timeliness	3	100%
Provider and Member Notification Timeliness	3	100%
Clinical Decision Making	3	33.33%
Accuracy	3	100%
Written Response in Members Preferred Language	3	100%
Accuracy of Member Notification	3	66.67%

- Based on a focused review of three (3) OneCare Connect Standard Service Authorizations (MMP-SARAG-1) from April 2020 – June 2020, the lower compliance score of 33.33% was due to two (2) files not following clinical hierarchy guidelines.

- Based on a focused review of seven (7) OneCare Connect Standard Service Authorizations (MMP-SARAG-1) from April 2020 – June 2020, the lower compliance score of 66.67% for accuracy of member notice content was due to one (1) letter not being written in lay language.

Measures	Files Reviewed	Compliance Score
MMP Standard Service Authorization Requests - Behavioral Health		
File Classification	3	100%
Resolution Timeliness	3	100%
Provider and Member Notification Timeliness	3	100%
Clinical Decision Making	3	100%
Accuracy	3	100%
Written Response in Members Preferred Language	3	100%
Accuracy of Member Notification	3	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Measures	Files Reviewed	Compliance Score
MMP Standard Service Authorization Requests - Pharmacy		
Clinical Decision Making Accuracy and Processing Requirements	17	0%
Decision Making/Notification Timeliness	17	100%

- Based on a focused review of seventeen (17) OneCare Connect SARAG Standard Service Authorization Requests (MSSAR) for clinical decision making accuracy and processing requirements from April 2020 – June 2020, the lower compliance score of 0% was due to seventeen (17) files failing in one or more of the following measures:
  - The free text included in written member notifications exceeded the 6th grade reading level.
  - Incorrect case disposition and processing of partial approvals.
  - Inaccurate written approval notifications.

Measures	Files Reviewed	Compliance Score
MMP Standard Service Authorization Requests - Long Term Support Services		
File Classification	8	100%
Resolution Timeliness	8	100%
Provider and Member Notification Timeliness	8	100%
Clinical Decision Making	8	100%
Accuracy	8	100%
Written Response in Member's Preferred Language	8	100%
Accuracy of Member Notification	8	100%

Measures	Files Reviewed	Compliance Score
MMP Expedited Service Authorization Requests - Utilization Management		
File Classification	5	100%
Resolution Timeliness	5	20%
Provider and Member Notification Timeliness	5	80%
Clinical Decision Making	5	80%
Accuracy	5	100%
Written Response in Member's Preferred Language	5	100%
Accuracy of Member Notification	5	80%

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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- Based on a focused review of five (5) OneCare Connect Expedited Service Authorizations (MMP-SARAG-2) from April 2020 – June 2020:
  - The lower compliance score of 20% for resolution timeliness was due to four (4) files not meeting timeliness requirements for expedited authorizations.
  - The lower compliance score of 80% for provider and member notification timeliness was due to one (1) file not having evidence of provider notification.
  - The lower compliance score of 80% for clinical decision making was due to one (1) file not following clinical hierarchy guidelines.
  - The lower compliance score of 80% for accuracy of member notice content was due to one (1) approval letter not issued in the 6th grade reading level and not being written in lay language.

Measures	Files Reviewed	Compliance Score
MMP Expedited Service Authorization Requests - Pharmacy		
Clinical Decision Making Accuracy & Processing Requirements	3	0%
Decision Making/Notification Timeliness	3	100%

- Based on a focused review of three (3) OneCare Connect SARAG Expedited Service Authorization Requests (MESAR) for clinical decision making accuracy and processing requirements from April 2020 – June 2020, the lower compliance score of 0% was due to all three (3) files failing in one or more of the following measures:
  - Written member notifications in free text exceeded the 6th grade reading level.
  - Incorrect case disposition and processing of partial approvals.

Measures	Files Reviewed	Compliance Score
MMP Provider Payment Requests (Claims) - Paid		
Acknowledgement Timeliness	5	100%
Processing Accuracy	5	80%
Resolution Timeliness	5	100%
Interest Accuracy	5	100%
Check Clearing Timeliness	N/A	N/A

- Based on a focused review of five (5) paid non-contracted provider claims from April 2020 - June 2020, the lower compliance score of 80% was due to one (1) paid claim processed inaccurately.

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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Measures	Files Reviewed	Compliance Score
MMP Provider Payment Requests (Claims) - Denied		
Acknowledgement Timeliness	5	100%
Processing Accuracy	5	100%
Resolution Timeliness	5	N/A
Interest Accuracy	5	N/A
Check Clearing Timeliness	N/A	N/A

Measures	Files Reviewed	Compliance Score
MMP Standard Plan Level Appeals		
Classification Score	15	100%
Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	15	100%
Language Preference	15	100%
Clinical Decision Making	15	100%
Member Notice Content	15	0%
Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt	15	100%

- Based on a focused review of fifteen (15) OneCare Connect MMP Standard Plan Level Appeals (MSPLA) from April 2020 – June 2020, the lower compliance score of 0% for member notice content was due to all fifteen (15) resolution letters not being issued at the 6th grade reading level.

Measures	Files Reviewed	Compliance Score
MMP Expedited Plan Level Appeals		
Classification Score	3	100%
Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	3	100%
Language Preference	3	100%
Clinical Decision Making	3	0%
Member Notice Content	3	100%
Resolution of Appeals Resolved within 72 Hours	3	100%

- Based on a focused review of three (3) OneCare Connect MMP Expedited Plan Level Appeals from April 2020 – June 2020, the lower compliance score of 0% was due to three (3) resolution letters not being issued at the 6th grade reading level.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Measures	Files Reviewed	Compliance Score
MMP Independent Review Entity (IRE) Cases		
Classification Score	2	100%
Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	2	100%
Language Preference	2	100%
Clinical Decision Making	2	100%
Member Notice Content	2	0%
Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt or 72 Hours	2	0%

- Based on a focused review of two (2) OneCare Connect IRE cases from April 2020 – June 2020, the lower compliance score of 0% for member notice content was due to two (2) resolution letters not being issued at the 6th grade reading level.

Measures	Files Reviewed	Compliance Score
MMP Standard Grievances		
Classification Score	15	100%
Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	15	100%
Language Preference	15	100%
Member Notice Content	15	20%
Resolution of Grievance Resolved ≤ 30 Calendar Days of Receipt	15	100%

- Based on a focused review of fifteen (15) OneCare Connect written standard grievances from April 2020 – June 2020, the lower compliance score of 20% for member notice content was due to twelve (12) files failing for the following reasons:
  - Eight (8) files reviewed had resolution letters that did not address all of the members' grievances.
  - Nine (9) files reviewed had resolution letters not issued at the 6th grade reading level.
  - One (1) file reviewed had the date of when the plan received the grievance missing from the acknowledgment letter.
  - One (1) file reviewed did not appropriately identify a Potential Quality Issue (PQI) and did not receive review by a clinical nurse.

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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6. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
September 2020	91%	100%	94%	87%	91%	92%	97%	100%	96%	97%	100%	92%	100%
October 2020	83%	85%	88%	83%	93%	93%	95%	88%	93%	98%	77%	100%	100%
November 2020	85%	94%	97%	93%	84%	92%	93%	89%	95%	99%	60%	100%	97%

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for timeliness for November 2020. Of the thirty-eight (38) files received from the five (5) health networks, nine (9) files were deficient for timeliness. Deficiencies for the lower timeliness scores were due to the following:
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (24 hours)
  - Failure to meet timeframe for deferred decision (14 calendar days)

- Based on a focused review of select files, two (2) health networks drove the lower compliance letter score for November 2020. Nine (9) of the sixteen (16) files received from the two (2) health networks were deficient for letter language. Deficiencies for the lower letter scores were due to the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2020	86%	95%	89%	86%
October 2020	92%	98%	99%	94%
November 2020	88%	85%	90%	85%

  - Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 92% in October 2020 to 88% in November 2020 due to untimely processing of claims. The lower score was driven by two (2) health networks that had three (3) out of the ten (10) files submitted marked as deficient.

  - Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 98% in October 2020 to 85% in November 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by four (4) health networks that had ten (10) out of the forty-two (42) files submitted marked as deficient.

  - Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 99% in October 2020 to 90% in November 2020 due to one (1) health network that failed to submit files for review.

  - Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 94% in October 2020 to 85% in November 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by five (5) health networks that had twenty-eight (28) out of the one hundred and seventy-one (171) files submitted marked as deficient.

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
September 2020	86%	Nothing to Report	90%	100%	90%	100%	100%	100%
October 2020	93%	100%	95%	98%	97%	100%	97%	99%
November 2020	94%	Nothing to Report	80%	100%	92%	84%	93%	100%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness of denials during the month of November 2020. Four (4) out of the twelve (12) files received from the two (2) health networks were deficient for timeliness. The deficiency for the lower score for timeliness was due to failure to meet the timeframe for provider notifications.

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making (CDM) during the month of November 2020. The one (1) file submitted for this health network was deficient due to a failure to cite criteria for decision.

- Based on a focused review of select files, three (3) health networks drove the lower compliance letter score. Of the thirty-four (34) files received from the three (3) health networks, twenty-six (26) files were deficient for letter language. The deficiencies for the lower letter score were due to the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2020	94%	100%	86%	93%
October 2020	100%	100%	100%	96%
November 2020	88%	86%	88%	88%

- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 100% in October 2020 to 88% in November 2020 due to untimely processing of claims. Of the ten (10) files submitted by the two (2) health networks, one (1) file was marked deficient for timeliness due to non-submission of the requested file.

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 100% in October 2020 to 86% in November 2020 due to missing documents that are required for processing accurate payment on a claim. The lower score was driven by three (3) health networks. Of the fifteen (15) files submitted, two (2) files were marked deficient for accuracy from two (2) of the three (3) health networks. One (1) health network failed to submit files for review and was marked deficient.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 100% in October 2020 to 88% in November 2020 due to untimely processing of a claim. The lower score was driven by one (1) health network that failed to submit files for review and was marked deficient for timeliness.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 96% in October 2020 to 88% in November 2020 due to missing documents that are required for processing accurate payment on a claim. The lower score was driven by one (1) health network with two (2) files submitted and one (1) file marked deficient for accuracy.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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8. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): 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
September 2020	100%	100%	96%	90%	91%	86%	93%	98%	90%	93%	100%
October 2020	88%	93%	92%	97%	94%	85%	87%	96%	83%	92%	99%
November 2020	83%	98%	95%	98%	92%	84%	85%	95%	77%	92%	100%

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for timeliness during the month of November 2020. Of the thirty-two (32) files submitted by the five (5) health networks, sixteen (16) files were deficient for timeliness. Deficiencies for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (routine – 5 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification

- Based on a focused review of select files, six (6) health networks drove the lower compliance score for clinical decision making (CDM) during the month of November 2020. Of the twenty-seven (27) files submitted by the six (6) health networks, sixteen (16) files were deficient for CDM. The lower scores for CDM were due to the health networks' failure to cite criteria for decision.

- Based on a focused review of select files, four (4) health networks drove the lower compliance letter score during the month of November 2020. Of the forty-two (42) files submitted by the four (4) health networks, twenty-six (26) files were deficient for letter language. Deficiencies for the lower letter scores were due to the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2020	80%	90%	100%	97%
October 2020	97%	98%	100%	99%
November 2020	87%	85%	90%	91%

- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 97% in October 2020 to 87% in November 2020 due to untimely processing of claims. The lower score was driven by three (3) health networks with an aggregate of twenty (20) files submitted and four (4) files marked deficient for timeliness.

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 98% in October 2020 to 85% in November 2020 due to missing documents that are required for processing accurate payment on a claim. The lower score was driven by four (4) health networks with an aggregate of thirty (30) files submitted and seven (7) files marked deficient for accuracy.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 100% in October 2020 to 90% in November 2020 due to untimely processing of a claim. The lower score was driven by two (2) health networks with nine (9) files submitted and one (1) file marked deficient for timeliness.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 99% in October 2020 to 91% in November 2020 due to missing documents that are required for processing accurate payment on a claim. The lower score was driven by one (1) health network that failed to submit files for review and was marked deficient.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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9. Delegation Oversight 2020 Annual Audits:

- As part of its annual audits for delegation oversight, CalOptima's Audit & Oversight department conducted file reviews and webinars for each health network for the look back period of July 1, 2019 – June 30, 2020 to assess the following delegated functions:

Access & Availability	Medi-Cal Addendum
Care Delivery Model	Member Grievances & Appeals
Claims	Network Management
Compliance	Provider Network Contracting
Credentialing	Provider Relations
Cultural & Linguistics	Quality Improvement
Customer Service	Sub-Contractual
Encounters	Translation Services
Information Systems	Whole Child Model
Mailroom Process	Utilization Management
Marketing	

- Non-Clinical Policy Review

Audit Areas	Access & Availability	Claims	Compliance	Cultural & Linguistics	Customer Service	Encounters	Information System	Marketing	Mailroom	Network Management	Provider Network	Provider Relations	Sub-Contractual	Translation Services
Overall Average Score	99%	99%	99%	100%	99%	100%	99%	100%	100%	100%	100%	99%	100%	100%

➢ CalOptima's Audit & Oversight (A&O) department audited fourteen (14) health networks' compliance with policy and procedures as they relate to the non-clinical areas listed above. The scores reflect the overall average across all health networks audited during calendar year 2020. Deficiencies identified include, but may not be limited to:
  - Failure to submit updated policies and procedures for the areas assessed.
  - Failure to submit supporting evidence (i.e., meeting minutes, sign-in sheets, reports) that meet audit elements for the areas assessed.

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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- Corrective action plans (CAPs) were issued to each health network with deficiencies identified. CalOptima's Audit & Oversight (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 compliance with regulatory requirements. Remediation efforts will be validated during the 2021 Delegation Oversight Annual Audits.

- Non-Clinical File Review

Audit Area	Claims	Customer Service Call Center Monitoring	Grievances
Overall Average Score	98%	99.86%	100%

- As part of its annual audits for delegation oversight, CalOptima's Audit & Oversight (A&O) department also performed file reviews of its health networks for the areas listed above. The audit assessed the compliance of the health networks' processes and timeliness as it relates to claims, customer service, and grievances. The scores reflect the overall average across all health networks audited during calendar year 2020.

- Corrective Action Plans (CAPs) were issued to each health network with deficiencies identified. CalOptima's Audit & Oversight (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 compliance with regulatory requirements. Remediation efforts will be validated during the 2021 Delegation Oversight Annual Audits.

- Clinical Policy Review

Audit Area	Care Delivery Model	Medi-Cal Addendum	Quality Improvement	Utilization Management	Whole Child Model	Member Grievance
Overall Average Score	95%	96%	98%	99%	94%	100%

- As part of its annual audits for delegation oversight, CalOptima's Audit & Oversight (A&O) department audited fourteen (14) health networks' compliance with policy and procedures as they relate to the areas listed above. The scores reflect the overall average across all health networks audited during calendar year 2020.

- Corrective Action Plans (CAPs) were issued to each health network with deficiencies identified. CalOptima's Audit & Oversight (A&O) department continues to work with each health network to remediate the deficiencies by identifying accurate root causes

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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 compliance with regulatory requirements. Remediation efforts will be validated during the 2021 Delegation Oversight Annual Audits.

- Clinical File Review (Utilization Management Prior Authorization)

Audit Area	Carve-Outs (Medi-Cal)	Urgent Concurrent (Medi-Cal)	Retrospective (Medi-Cal)	Termination (Medi-Cal)	Suspension (Medi-Cal)	Reduction (Medi-Cal)	Notice of Medicare Non-Coverage (OneCare)	Notice of Medicare Non-Coverage (OneCare Connect)
Overall Average Score	96%	67%	78%	93%	Nothing to Report	Nothing to Report	76%	79%

- As part of its annual audits for delegation oversight, CalOptima's Audit & Oversight (A&O) department performed clinical file reviews of its fourteen (14) health networks for compliance with timeliness, letter language, and clinical decision making as they related to the areas listed above. The scores reflect the overall average across all health networks audited during calendar year 2020.

- Corrective Action Plans (CAPs) were issued to each health network with deficiencies identified. CalOptima's Audit & Oversight (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 compliance with regulatory requirements. Remediation efforts will be validated during the 2021 Delegation Oversight Annual Audits.

- Credentialing & Recredentialing

Audit Area	Credentialing Policy Review	Initial Credentialing File Review	Recredentialing File Review	Organizational Providers' Initial File Review	Organizational Providers' Recredentialing File Review
Overall Average Score	99%	97%	97%	97%	98%

- As part of its annual audits for delegation oversight, CalOptima's Audit & Oversight (A&O) department performed an audit on its fourteen (14) health networks to assess their compliance with policy and procedures as they relate to credentialing. The scores reflect the overall average across all health networks audited during calendar year 2020.

- Corrective Action Plans (CAPs) were issued to each health network with deficiencies identified. CalOptima's Audit & Oversight (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,

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process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure compliance with regulatory requirements. Remediation efforts will be validated during the 2021 Delegation Oversight Annual Audits.

10. First Tier Entities (FTE):

- CalOptima's Audit & Oversight department conducted annual audits of thirteen (13) first-tier entities (FTE) to ensure compliance with applicable laws, regulations, contractual requirements, and CalOptima policies. FTEs included, but may not be limited to, printing and fulfillment vendors, translation and interpreter vendors, enrollment and eligibility verification vendor, home health and hospice service vendors, over-the-counter benefit vendor, pharmacy formulary services vendor, timely access survey vendor, and personal emergency response services vendor. The audit areas assessed included the contractual, compliance, information systems, insurance, and sub-contractual obligations of the FTE. The scores below reflect the overall average across all thirteen (13) FTEs audited during calendar year 2020.

Audit Area	Contractual Obligations	Compliance	Information Systems	Insurance	Sub-Contractual
Overall Average Score	99.62%	98%	99%	97%	90%

- Corrective Action Plans (CAPs) were issued to all FTEs with identified deficiencies. CalOptima's Audit & Oversight department continues to work with each FTE 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 compliance with regulatory requirements. Remediation efforts will be validated during the FTE's next annual audit in 2021.

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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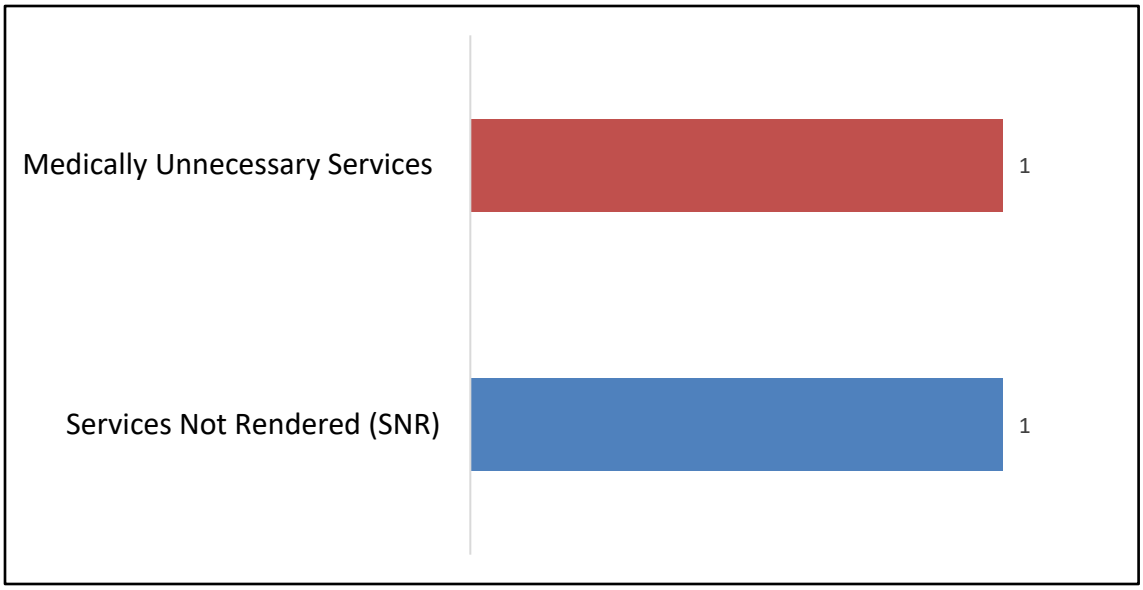
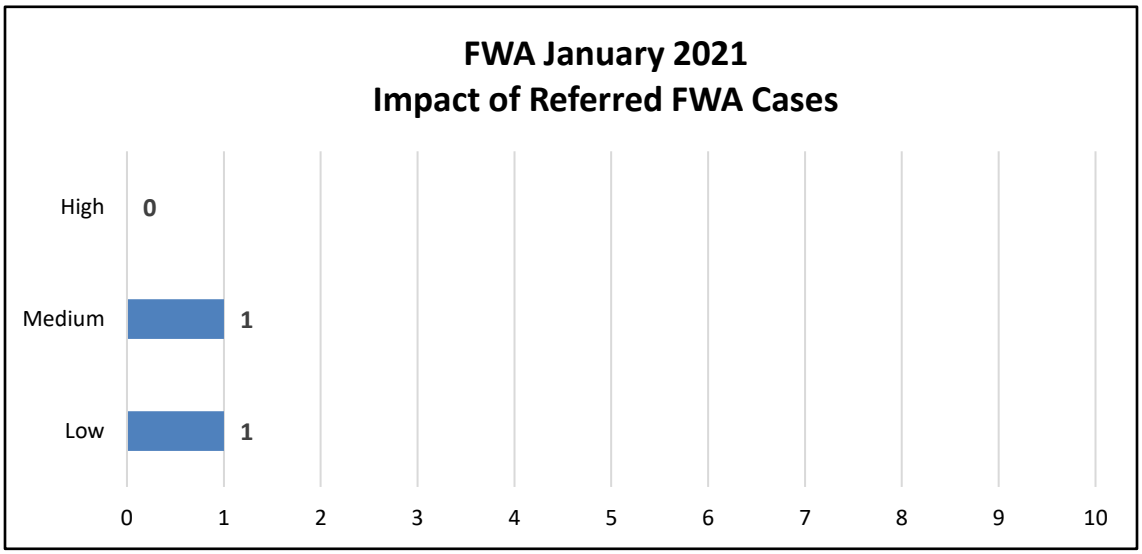
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in January 2021)





Total Number of New Cases Referred to DHCS (State)	2
Total Number of Closed Cases Referred to I-MEDIC (CMS)	0
Total Number of Referrals Reported	**2**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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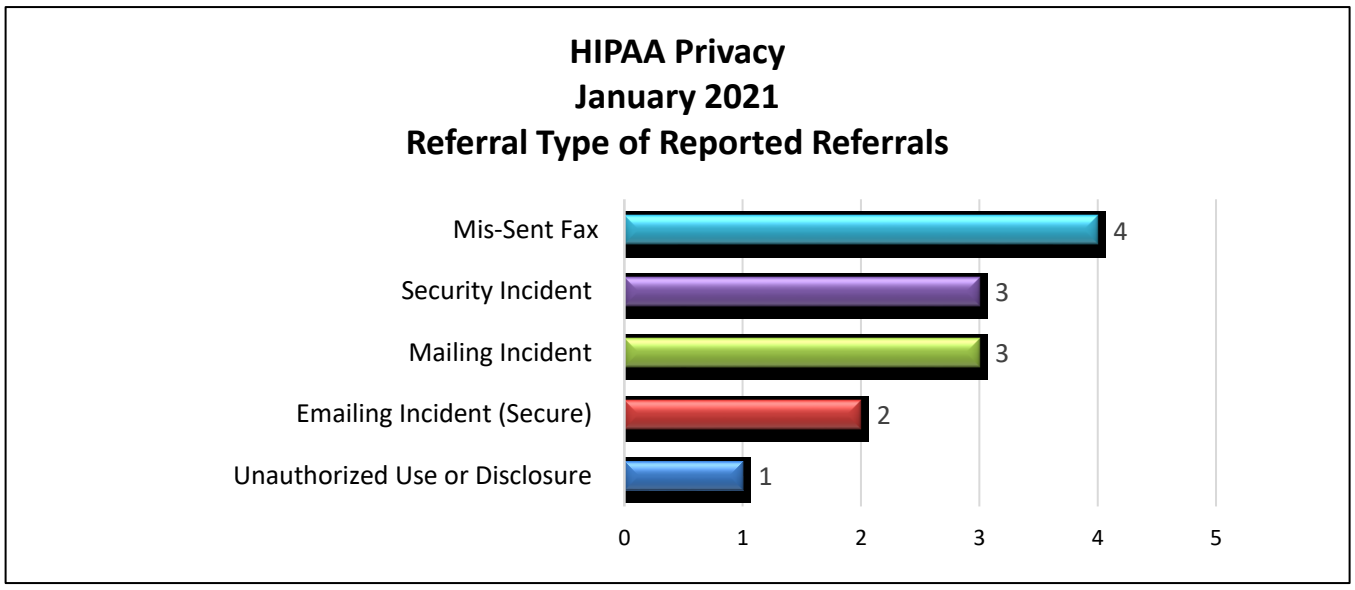
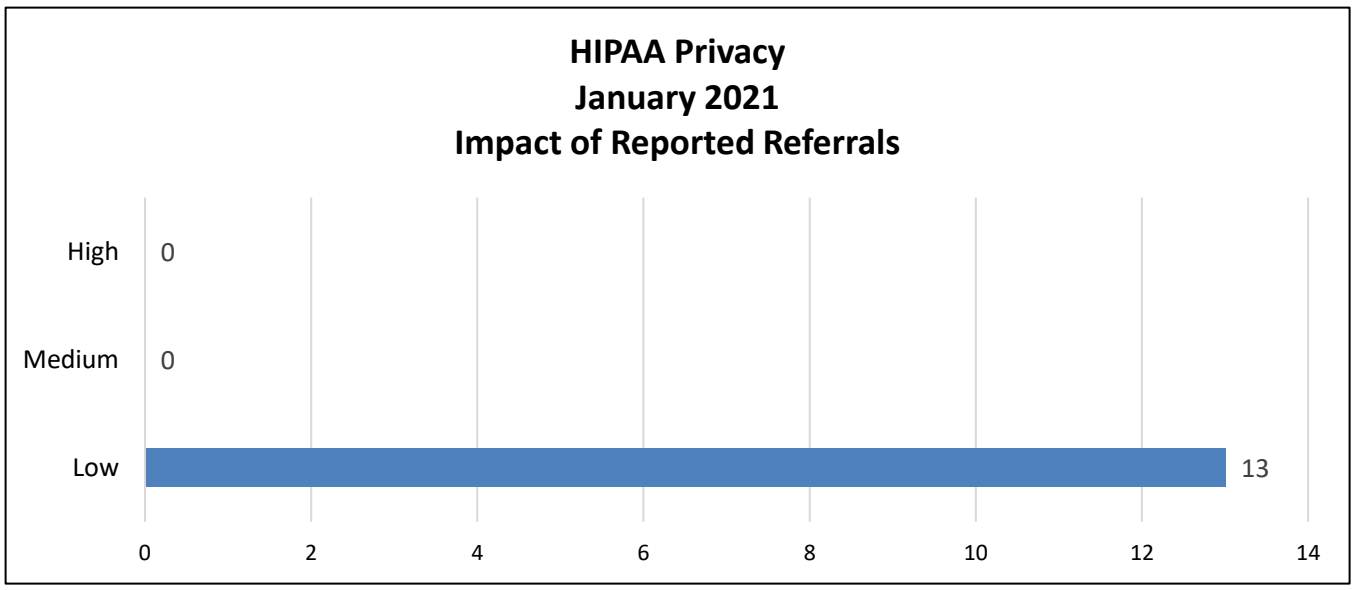
E. Privacy Update: (January 2021)





Total Number of Referrals Reported to DHCS (State)	13
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**13**

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

February 16, 2021

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: February Board of Directors Report

Legislation continues to advance via the budget reconciliation process, with Democrats hoping to send a $1.9 trillion stimulus package to President Biden by mid-March. Meanwhile, House and Senate Committees remain focused on COVID-19 response and vaccine distribution, amid concerns over new strains of the virus. This report covers developments through February 15, 2021.

Budget Reconciliation/COVID Package

The House and Senate on February 5 agreed to a Fiscal Year (FY) 2021 budget resolution that lays the foundation for the budget reconciliation process Democrats will use to advance a massive COVID-19 relief package. The Senate voted 51-50 to approve the resolution (S.Con.Res.5), with Vice President Kamala Harris as the tie breaker, following an all-night "vote-a-rama" that saw a handful of amendments adopted, including an amendment from Sen. Susan Collins (R-ME) to strengthen the Provider Relief Fund and include a set-aside for rural hospitals.

The budget resolution instructed the committees of jurisdiction to write and mark up their portions of a $1.9 trillion stimulus plan. The committees will send their proposals to the House Budget Committee, which will package the bills together for the floor. Democratic leaders aim to send a final measure to the President's desk by March 14, the date when CARES Act unemployment provisions will expire.

Committees have outlined the policies they plan to include in the legislation, including COVID-19 vaccine funding, $1,400 direct stimulus checks, state and local aid, and a phased-in increase of the federal minimum wage. The House Energy and Commerce and Ways and Means Committees also have recommended an array of health care policies. Over a two-day markup, the Energy and Commerce Committee advanced four legislative proposals that provide: $14 billion for vaccines; $46 billion for testing, contact tracing, and mitigation; $7.6 billion to hire 100,000 full-time public health workers to support COVID-19 response; $25 billion to address health disparities; and $4 billion for behavioral and mental health services. The Energy and Commerce portion of the reconciliation package also includes a number of legislative recommendations related to Medicaid, including the following provisions:

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- Mandatory coverage of COVID-19 vaccines, vaccine administration, and treatment under Medicaid;
- Flexibility for states to extend Medicaid eligibility to women for 12 months postpartum;
- Medicaid coverage for incarcerated individuals 30 days prior to their release;
- Enhanced Federal Medical Assistance Percentages (FMAP) for bundled community-based mobile crisis intervention services;
- Temporary FMAP increase of five percentage points for states that newly expand Medicaid;
- Extension of 100 percent FMAP for services provided to Medicaid beneficiaries receiving care through Urban Indian Organizations and Native Hawaiian Health Care Systems;
- Elimination of the cap on Medicaid drug rebates starting in 2023; and
- Temporary FMAP increase of 7.35 percentage points for states to make improvements to Medicaid home- and community-based services for one year.

The Ways and Means Committee also marked up and advanced its portion of the COVID package. Among other provisions, the Committee's recommendations:

- Increase Affordable Care Act (ACA) premium tax credits for 2021 and 2022;
- Subsidize COBRA coverage through the end of the fiscal year;
- Create health care subsidies for unemployed workers who are ineligible for COBRA;
- Provide funding for state "strike teams" to manage COVID-19 outbreaks in skilled nursing facilities (SNFs); and
- Extend the Families First Coronavirus Response Act paid sick time and paid family leave credits from March 31, 2021 through September 30, 2021.

The Senate is able to pass reconciliation legislation by a simple majority vote but is subject to the Byrd Rule, under which Senators can strike any provision of the bill that does not have a direct budgetary impact. As such, some policies—such as the minimum wage increase—may be dropped during the reconciliation process.

Committee Hearings

While many Senate committees are still organizing, House committees continue to hold multiple hearings on the COVID-19 crisis. On February 3, the Energy and Commerce Health Subcommittee held a hearing on COVID-19 response with a focus on the medical supply chain. On February 2, the Energy and Commerce Oversight and Investigations Subcommittee held a hearing with several state officials to discuss ways to ramp up COVID-19 vaccinations in the states. Members on both sides of the aisle called for greater transparency into the nation's vaccine supply. The Subcommittee will hold a hearing on February 23 with vaccine manufacturers, including AstraZeneca, Johnson & Johnson, Moderna, Novavax, and Pfizer.

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On February 23, the Senate Health, Education, Labor and Pensions (HELP) Committee will hold a hearing to consider the nomination of Xavier Becerra to serve as Secretary of Health and Human Services (HHS). Becerra has been Attorney General of California since 2017 and is known as a staunch defender of the ACA. The Senate Finance Committee also plans to hold a confirmation hearing for Becerra, though a date has not yet been set.

Executive Orders

President Biden has signed a number of Executive Orders during his first month in office, many of them related to COVID-19. An order signed on January 20 created the position of COVID-19 Response Coordinator within the White House and outlined priorities including: reducing disparities in COVID-19 treatment and response; managing efforts to produce and supply personal protective equipment (PPE); expanding testing capabilities; and supporting the distribution of vaccines. Biden also halted the U.S. withdrawal from the World Health Organization (WHO) and directed the Secretary of Health and Human Services to accelerate the development of treatments for COVID-19.

On January 28, President Biden signed an "Executive Order on Strengthening Medicaid and the Affordable Care Act." The order called for a Special Enrollment Period on the federally facilitated exchanges for uninsured and underinsured individuals during the pandemic. The Centers for Medicare and Medicaid Services (CMS) subsequently announced that it would open a Special Enrollment Period starting February 15 and continuing through May 15, 2021. The order also directs the Secretaries of Labor, Health and Human Services, and Treasury to review all existing regulations and policies and consider revising or rescinding any policies that undermine insurance affordability and access, including coverage through Medicaid or the exchanges.

On February 2, the President signed an "Executive Order on Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans." Among other immigration policies, the order mandates the immediate review of all agency actions related to implementation of the previous Administration's "public charge" rule, which gave the federal government additional authorities to deny residency applicants for individuals who have received or are considered likely to receive public assistance, such as Medicaid. The order signals that the public charge rule is likely to be reversed or changed significantly, though this process will likely require formal rulemaking or a court order.

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ACA Case

Edwin Kneedler, Deputy Solicitor General of the United States, sent a letter on February 10 notifying the Supreme Court that the Department of Justice is reversing its position in *California v. Texas*, the high-profile case concerning the constitutionality of the Affordable Care Act. The previous administration had argued that the health law should be overturned following the effective elimination of the individual mandate penalty in 2017 under the Tax Cuts and Jobs Act.

The reversal is not expected to have much impact on the results of the case, and the Department of Justice did not file a supplemental briefing. A final decision in *California v. Texas* could come at any time, but most observers expect a ruling in June.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

February 12, 2021

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

This week, proponents of the effort to recall Governor Newsom announced that they have surpassed the 1.5 million signatures required to qualify the recall election. They acknowledged, however, that more signatures are needed to ensure that there are enough verifiable signatures to qualify.

As the recall effort picks up steam, Governor Newsom's allies have rallied to him. In the last week or so the Governor has held press conferences at mass vaccine clinics in Oakland, San Diego, Santa Clara, and Fresno. The Governor has been joined by local elected officials and state legislators from his own party, all of whom praised his efforts to combat the pandemic.

Throughout the pandemic Senator Steve Glazer, a Democrat who represents Contra Costa and parts of Alameda County has regularly critiqued the state's handling of the pandemic, calling for a more aggressive response. This week, Senator Glazer acknowledged the differences between himself and the Governor on policy, but unequivocally stated that none of the Governor's actions have been worthy of recall. For most, this is nowhere near as noteworthy as the public announcement from the White House opposing the recall. However, Senator Glazer's announcement reflects how seriously Sacramento Democrats are taking the need to publicly defend the Governor from recall.

Paradoxically, the Legislature seems to be emboldened to push back on the Governor's priorities, ignore his deadlines, and question his policies in less high-profile ways. Several examples follow.

School Reopening
Since California's shelter in place order went into effect last March, few problems have frustrated Californians more than the inability to reopen classrooms for students. In addition to the potential impact on learning, working parents have struggled with the need to wear a teacher's hat while balancing their family's other needs.

Recognizing this, Governor Newsom announced a plan to provide $2 billion in grants for in-person instruction at the end of December. The Governor's called upon the Legislature to act on the proposal, which would have provided funding for better safety standards in schools and testing, "immediately" with the goal of getting kindergarten through 2nd grade students back in schools by mid-February and the remainder of elementary school students by March.

However, the Legislature has yet to adopt a spending plan. With over 300,000 members statewide and hundreds of millions available for campaign spending, the California Teachers Association (CTA) is widely recognized as the most influential

stakeholder in Sacramento. Mirroring negotiations and conflict at the local level, CTA has pushed for vaccination to be a precondition of school employees returning to work among other things. With those concerns expressed to Democrats in the Legislature, the Governor's proposal stalled in January.

Instead, the Governor has stated that he and the Legislature will be concluding negotiations on a $6.6 billion compromise agreement at the end of this week. The basis of those negotiations has been reported on in the news, and calls for a slower phased approach to reopening schools with teachers and other employees being able to stay home until vaccinated. If adopted by the Legislature, it remains to be seen how quickly students will be able to return to the classroom.

Vaccine Roll Out and State Lab

In October, Governor Newsom announced the opening of a state lab in Valencia which he hoped would increase testing by 75%. The state entered into a $1.7 billion contract for operation of the lab with PerkinElmer, a Massachusetts based diagnostics machinery company, without opening the contract to competing bids from laboratories.

This week, CBS affiliated Channel 13 in Sacramento reported on serious problems at the Valencia lab following whistleblower complaints. The lab is contracted to provide 150,000 tests per day by March. The local news station found that the lab is currently processing only 20,000, tests per day but billing the state for 100,000. Other issues included reports of technicians sleeping on the job, test swabs found in restroom trash, and a relatively high rate of inconclusive test results.

Both the Governor and his Department of Public Health (DPH) have faced withering criticism from the media. This week, the Assembly Budget Subcommittee with jurisdiction over healthcare issues held a hearing on budget issues pertaining to DPH. The hearing focused largely on the state's plans to roll out vaccines, with legislators expressing frustration with the speed and shifting strategy for roll out. At the same time Assemblymember Blanca Rubio, who leads the Assembly's informal caucus of moderate Democrats, asked several pointed questions about whether the Valencia Lab was meeting its goals, and whether it had been wise to enter into a "no-bid" contract. DPH was unable to answer those questions during the hearing.

Immediate Budget Actions

When presenting his January Budget, Governor Newsom requested that the Legislature take "immediate action" on $5 billion worth of pandemic relief and economic stimulus. That includes the $2 billion for schools discussed above, a $2.4 billion low-income tax credit, $550 million in small business grants, and fee waivers for businesses. The Governor referred to approval in the next few weeks when presenting the budget in early January. The media largely interpreted this as meaning before the end of January.

The Legislature seems to have had a different interpretation. To date they have not adopted any of the Governor's immediate action items, though hearings are underway.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 93 Garcia	**Prioritization of Food Supply Industry Workers:** Would prioritize workers in the food supply industry, such as field workers and grocery workers, for rapid testing and vaccination programs in response to pandemics, including COVID-19.	**12/07/2020** Introduced	CalOptima: Watch
AB 449 Voepel	**COVID-19 Hospital Reporting**: States the intent of the author to introduce legislation that would require hospitals to submit an annual report regarding deaths due to COVID-19, gender demographics for those who died, and the total reimbursement that a hospital received for costs related to the treatment of COVID-19 from 2020–21. Reporting would begin in 2022 and would be submitted to the State Legislature.	**02/08/2021** Introduced	CalOptima: Watch
SB 242 Newman	**Provider Reimbursement for Medically Necessary Equipment:** Would allow physicians and dental providers to be reimbursed for medically necessary equipment to treat and reduce the spread of COVID-19 or other infectious diseases in the workplace. Reimbursable equipment would include personal proactive equipment, infection control supplies, testing and diagnostic supplies, contact tracing, or other related information technology expenses. The reimbursement rates would be determined by the Department of Health Care Services (DHCS).	**01/21/2021** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 77 Petrie-Norris	**Jarrod's Law:** States the intent of the author to introduce legislation that would require DHCS to administer a licensing process for inpatient and outpatient substance use disorder treatment programs that are not otherwise required to be licensed under current law.	**12/07/2020** Introduced	CalOptima: Watch
SB 106 Umberg	**Mental Health Services Act (MHSA) Focus Populations:** States the intent of the author to introduce legislation that would update the MHSA to further address individuals with mental illness who are also experiencing homelessness or are involved in the criminal justice system. Updates to the MHSA would also address early intervention efforts for youth experiencing a mental illness.	**01/05/2021** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 256 Pan	**CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS):** Would require ECM to be included as a covered benefit for Medi-Cal beneficiaries. This would include the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require a Medi-Cal managed care plan (MCP) to list available ILOS on the health plan's website and in the beneficiary handbook as well as share data with DHCS related to beneficiary utilization of ILOS. ILOS offered by the health plan must be incorporated into DHCS' methodology for calculating the MCP's capitation rate.	**01/26/2021** Introduced	CalOptima: Watch
TBD Trailer Bill	**CalAIM:** Would codify various provisions of the CalAIM Proposal as revised by DHCS on January 8, 2021, for which implementation requires changes in state law.	**02/01/2021** Published on the Department of Finance website	CalOptima: Watch

CHILDREN'S SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 66 Buchanan	**CARING for Kids Act:** Would permanently extend authorization and funding of the Children's Health Insurance Program (CHIP) and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs.	**01/04/2021** Introduced	CalOptima: Watch
AB 393 Reyes	**Early Childhood Development Act of 2020:** Effective immediately, would require the California Department of Social Services (CDSS) to conduct an evaluation of emergency childhood services provided during the COVID-19 public health emergency, including the following: ■ Availability of crisis childcare services ■ Availability of COVID-19 testing and personal protective equipment ■ Vaccination prioritization and distribution ■ Cleaning of childcare centers ■ Payment to family childcare homes during state-mandated closures ■ Foster care programs CDSS would be required to submit its findings and associated recommendations to the State Legislature by October 1, 2021.	**02/02/2021** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 56 Biggs	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include a food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, CHIP and Medicaid, as a mandatory benefit.	**01/04/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 114 Maienschein	**Rapid Whole Genome Sequencing:** Would add rapid Whole Genome Sequencing as a covered Medi-Cal benefit. The benefit would include individual sequencing, trio sequencing for parents and their baby, and ultra-rapid sequencing.	**12/17/2020** Introduced	CalOptima: Watch
AB 342 Gipson	**Colorectal Cancer Screenings and Colonoscopies:** Effective January 1, 2022, would require health plans to provide no-cost coverage for all colorectal cancer screenings and laboratory tests recommended by the U.S. Preventive Services Task Force and Medicare. Additionally, would prohibit health plans from imposing cost sharing on colonoscopies for those between 50 and 75 years of age. Health plans would not be required to comply with these provisions when the service was delivered by an out-of-network provider.	**01/28/2021** Introduced	CalOptima: Watch
SB 306 Pan	**Sexually Transmitted Disease (STD) Home Test Kits:** Would require health plans to provide coverage and reimbursement for at-home, FDA-approved STD test kits and any associated laboratory fees. Subject to funding by the State Legislature, would also authorize Medi-Cal reimbursement for STD-related services at the same rate as comprehensive family planning services, even when the patient is not at risk of becoming pregnant or in need of contraception.	**02/04/2021** Introduced	CalOptima: Watch
RN 21 05566 Trailer Bill	**Delayed Suspension of Medi-Cal Adult Optional Benefits:** Would delay the suspension of certain Medi-Cal adult optional benefits, which are currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Extended optional benefits include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch
RN 21 05595 Trailer Bill	**Delayed Suspension of Medi-Cal Postpartum Care Extension:** Would delay the suspension of Medi-Cal postpartum expanded eligibility, which is currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Postpartum expanded eligibility allows Medi-Cal beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition, to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of pregnancy. Upon the discontinuation of postpartum expanded eligibility on December 31, 2022, postpartum care would terminate 60 days after the last day of pregnancy.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office previously projected this expansion would cost approximately $900 million General Fund (GF) in 2019–20 and $3.2 billion GF each year thereafter, including the costs of In-Home Supportive Services.	**12/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 112 Holden	**Inmate Eligibility Extension:** Would delay the termination date of Medi-Cal eligibility for non-juvenile inmates from one year of elapsed incarceration to three years of elapsed incarceration. For juvenile inmates, Medi-Cal eligibility would not be terminated until three years after their status as a juvenile has ended. While Medi-Cal benefits and payments would still be suspended throughout incarceration, as required by federal law, this bill would allow inmates to remain Medi-Cal eligible for a longer period before termination. The lengthened eligibility period would allow more inmates to immediately reinstate their benefits upon release, rather than initiate the standard redetermination process.	**12/17/2020** Introduced	CalOptima: Watch
AB 470 Carrillo	**Elimination of Asset Consideration:** States the intent of the author to introduce legislation that would prohibit the consideration of an individual's assets when determining Medi-Cal eligibility.	**02/08/2021** Introduced	CalOptima: Watch
SB 56 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million GF, $21 million federal funds) for approximately 25,000 undocumented seniors. In-Home Supportive Services are estimated to cost $13 million GF.	**12/07/2020** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 71 Rivas, Luz	**Bring California Home Act:** Would create the Bring California Home Fund in the State Treasury to fund a statewide homelessness solutions program. Funds would be derived from specified rate increases and other adjustments in the personal income tax and corporate income tax structures. Would authorize the Homeless Coordinating and Financing Council and the Department of Housing and Community Development to jointly administer the funds to applicants, including counties, cities and developers, for the purpose of reducing the number of individuals experiencing homelessness. Eligible uses of funding would include rental assistance, landlord incentives, housing navigation services, and the development and operation of permanent affordable housing and transitional housing projects.	**12/07/2020** Introduced	CalOptima: Watch
AB 362 Quirk-Silva	**Homeless Shelter Safety:** States the intent of the author to introduce legislation that would require homeless shelters receiving certain grants to comply with health and safety regulations to improve the shelters' condition.	**02/01/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 369 Kamlager	**Presumptive Eligibility and Street Medicine Payment:** Would require DHCS to apply presumptive Medi-Cal eligibility — with full-scope benefits and without share of cost — to individuals experiencing homelessness. Hospitals would be permitted to determine presumptive eligibility. Would also require DHCS to establish a Medi-Cal fee-for-service payment system to reimburse providers who deliver on-street medical services to individuals experiencing homelessness. Such services would not need to be provided by or require a referral from an assigned primary care physician. DHCS would issue a benefits identification card to those receiving services, but providers would not be required to verify the identity of the individual at the time of service. Additionally, would prohibit DHCS from requiring prior authorization or other utilization management of any services related to COVID-19, including testing, treatment, and prevention, through January 1, 2026.	**02/01/2021** Introduced	CalOptima: Watch

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 08473 Trailer Bill	**Delayed Proposition 56 Suspensions:** Would delay the suspension of certain value-based payment (VBP) programs authorized under Proposition 56, which are currently set to expire on July 1, 2021. For VBP programs aimed at improving behavioral health integration, DHCS would suspend payments after spending a total of $95 million. For all other VBP programs, DHCS would suspend payments on July 1, 2022.	**02/04/2021** Published on the Department of Finance website	CalOptima: Watch

HEALTH EQUITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 17 Pan	**Racism as a Public Health Crisis:** Would require the California Department of Public Health (CDPH) to collaborate with the Office of Health Equity, Health in All Policies Program, and other departments and stakeholders to address racism as a public health crisis.	**12/07/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 97 Nazarian	**Insulin Affordability:** States the intent of the author to introduce legislation that would make insulin more affordable for Californians.	**12/08/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 40 Hurtado	**California Medicine Scholars Program:** Would require California's Office of Statewide Health Planning and Development (OSHPD) to establish the California Medicine Scholars Program (CMSP) as a five-year pilot program, effective January 1, 2023. In order to address the shortage of primary care physicians and the growing health disparities in underserved communities, the CMSP would serve as a pipeline for community college students to pursue premedical training and enter medical school. The CMSP would be administered by a contracted entity through four regional hubs, each comprised of a four-year university, medical school, community colleges and local organizations.	**12/17/2020** Introduced	CalOptima: Watch
SB 221 Wiener	**Timely Access to Care:** Would codify current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require *follow-up* appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment—in alignment with the current time frame for the initial appointment. Although this bill would modify the Knox-Keene Act, which does not apply to CalOptima, DHCS would be expected to align standards in the Medi-Cal managed care contracts in accordance with current practice.	**01/13/2021** Introduced	CalOptima: Watch

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 265 Petrie-Norris	**Laboratory Services Reimbursement:** Would remove the current requirement that DHCS cannot reimburse Medi-Cal fee-for-service providers for clinical laboratory or laboratory services at a rate that exceeds 80% of the lowest maximum allowance established by the federal Medicare program for the same service. Federal legislation enacted in 2018 established new Medicare rates for lab services, which resulted in automatic cuts to Medi-Cal reimbursement rates that are now often below the cost of service.	**01/15/2021** Introduced	CalOptima: Watch
SB 316 Eggman	**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 does not allow an FQHC to be reimbursed for mental or dental and physical health visits on the same day; a patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit (through the member's primary care provider) and a mental health or dental visit as two separate visits, regardless of whether the visits were at the same location on the same day. As a result, a patient would no longer be required to wait for 24 hours between medical and dental or mental health services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**02/04/2021** Introduced	CalOptima: Watch

SUBSTANCE USE

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 75 Bates	**Southern California Fentanyl Task Force:** Would establish the Southern California Fentanyl Task Force, under the direction of the Attorney General, to identify strategies to combat the fentanyl crisis. The task force would be comprised of representatives from the California Department of Justice (DOJ), California Highway Patrol and each county within Southern California. Would require the task force to hold its first meeting by July 1, 2022, and issue a report of its findings and recommendations to the Legislature and DOJ by January 1, 2025.	**12/15/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would permit the U.S. Secretary of Health and Human Services to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or Rural Health Clinic (RHC), as well as allow patients to receive telehealth services in the home without restrictions.	**01/19/2021** Introduced	CalOptima: Watch
S. 150 Cortez Masto	**Ensuring Parity in Medicare Advantage for Audio-Only Telehealth Act of 2021:** Would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage plans during the COVID-19 public health emergency.	**02/02/2021** Introduced	CalOptima: Watch
AB 32 Aguiar-Curry	**Telehealth Payment Parity and Flexibilities:** Would expand current law to require Medi-Cal MCPs, including County Organized Health Systems, to reimburse its contracted providers for telehealth services at the same rate as equivalent in-person health services. This requirement would also apply to any delegated entities of a Medi-Cal MCP, such as contracted health networks. Would allow providers to determine eligibility and enroll patients into Medi-Cal programs through audio-visual or audio-only telehealth services. Additionally, would require DHCS to indefinitely continue all telehealth flexibilities implemented during the COVID-19 pandemic. DHCS would be required to establish an advisory group to guide the development a long-term Medi-Cal telehealth policy.	**12/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 08394 Trailer Bill	**Medi-Cal Telehealth Proposal:** Would modify, extend or expand certain telehealth flexibilities adopted by DHCS during the COVID-19 pandemic to be incorporated into permanent law. Would allow FQHCs and RHCs to establish a patient within its federal designated service area through audio-visual telehealth. However, health care providers would be prohibited from establishing a patient through audio-only telehealth or other non-audio-visual telehealth modalities. Would also require DHCS to specify the Medi-Cal-covered health care benefits that may be delivered through telehealth services. DHCS and Medi-Cal MCPs would be required to reimburse audio-visual telehealth services at the same rate as in-person services, while audio-only, remote patient monitoring and other modalities may be reimbursed at different rates. Additionally, would allow Medi-Cal MCPs to include telehealth services when determining compliance with network adequacy standards without the use of alternative access standard requests.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch

WHOLE CHILD MODEL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 382 Kamlager	**Whole Child Model (WCM) Program Stakeholder Advisory Group:** Would extend the duration of the California Children's Services Advisory Group (CCS AG), which is currently scheduled to end on December 31, 2021, for an additional two years through December 31, 2023. The CCS AG, whose membership currently includes the CalOptima CEO and the Chair of CalOptima's WCM Family Advisory Committee, will continue to provide advice and recommendations to DHCS on the WCM program.	**02/02/2021** Introduced	CalOptima: Watch

*Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: February 9, 2021

2021 Federal Legislative Dates

January 3	117th Congress, First Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	First Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

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

Board of Directors Meeting
March 4, 2021

CalOptima Community Outreach Summary — February 2021

Background
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events and public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participate in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Event Update
CalOptima is committed to supporting our community in response to the global pandemic and economic decline. In January, Community Relations outreached to 26 community-based organizations, 37 community collaboratives and 21 shelters in Orange County to share CalOptima Medi-Cal educational materials with community partners and individuals they serve. This collaborative effort is intended to outreach to potential members who may be eligible for Medi-Cal and in need of health insurance but may not be aware of how or where to apply. It also will help inform CalOptima members about their Medi-Cal benefits.

CalOptima has developed three educational materials with information on the enrollment process as well as CalOptima and Medi-Cal benefits:

- Infographic on How to Enroll in Medi-Cal: English/Spanish and English/Vietnamese
- CalOptima Medi-Cal brochure: English, Spanish, Vietnamese, Korean, Arabic, Chinese and Farsi
- CalOptima Medi-Cal poster: English, Spanish, Vietnamese are currently available. Korean, Arabic, Mandarin and Farsi will be available in February.

The response from community stakeholders has been positive. Electronic copies of these materials were sent as part of our outreach. As of January 21, 2021, 12 partners requested hard copies of educational materials, five posted materials on their websites and social media platforms, 21 collaboratives shared with members of the collaborative, and three shared on their newsletters and listserv distributions. To highlight, Jamboree Housing

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Corp. will distribute materials at 39 affordable housing units. We have outreached to other affordable housing developers with the Housing for Health OC collaborative, Regional Center of Orange County shared materials through their client listserv distribution, and a presentation is scheduled in February for all staff at the FaCT Family Resource Centers.

Community Relations will continue to outreach to our community partners to share educational materials and provide presentations to increase awareness about Medi-Cal enrollment and benefits and CalOptima's programs and support services. 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 January 18, 2021, **through virtual meetings and teleconferences**, CalOptima expects to participate in 26 community events, coalition and committee meetings during February.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
2/2/2021	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
2/3/2021	• Anaheim Human Services Network Meeting (Virtual Meeting) • OC Aging Services Collaborative General Meeting (Virtual Meeting) • Orange County Healthy Aging Initiative/Orange County Strategic Plan for Aging Healthcare Committee Meeting (Virtual Meeting)
2/4/2021	• Continuum of Care Homeless Provider Forum (Virtual Meeting) • Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
2/8/2021	• Orange County Veterans and Military Families Collaborative — Children and Family Working Group (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
2/9/2021	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
2/10/2021	• Anaheim Homeless Collaborative Meeting (Virtual Meeting)
2/11/2021	• Buena Park Collaborative Meeting (Virtual Meeting) • Garden Grove Collaborative Meeting (Virtual Meeting) • Kid Healthy Community Advisory Committee Meeting (Virtual Meeting)
2/12/2021	• Senior Citizens Advisory Council General Meeting (Virtual Meeting)

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2/15/2021	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Virtual Meeting)
2/16/2021	• UCI Paul Merage School of Business 30th Annual Health Care Forecast Conference (Sponsorship fee: $1,000 included one conference admission ticket, recognition on host social media and e-communications, sponsorship listed in all printed and digital materials and website, company name and link on conference website and acknowledgement during the 4-day conference) (Virtual Conference) • Placentia Community Collaborative Meeting (Virtual Meeting) • Aging and Disability Resource Connection Advisory Committee Meeting (Virtual Meeting)
2/17/2021	• Covered Orange County Steering Committee Meeting (Virtual Meeting) • Orange County Communications Workgroup (Virtual Meeting) • Minnie Street Family Resource Center Professional Roundtable (Virtual Meeting)
2/22/2021	• Community Health Research Exchange Meeting (Virtual Meeting) • Stanton Collaborative Meeting (Virtual Meeting)
2/23/2021	• Clinic in the Park Collaborative Meeting (Virtual Meeting)
2/25/2021	• Orange County Care Coordination for Kids Collaborative Meeting (Virtual Meeting)

As of January 18, 2021, CalOptima expects to organize or convene two community stakeholder events, meetings or presentations through virtual meetings or teleconferences during February.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
2/18/2021	• Health Network Forum (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
2/8/2021	• Community-Based Organization Presentation to Cal State Fullerton Center for Healthy Neighborhood community members — Topic: Medi-Cal in Orange County (Spanish and English Virtual Presentation)

CalOptima provided two endorsements consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Letter of Support to Casa de la Familia for funding renewal from the California Victim Compensation Board to provide trauma-informed mental health services, case management and outreach to underserved survivors of trauma in Orange County.

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2. Letter of Support to Mind OC for the Youth Opioid Grant Be Well Orange County Alliance for Youth (BE OCAY) submitted to YOR California (a joint effort of California Institute for Behavioral Health Solutions and Advocates for Human Potential, Inc.)

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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 opportunity to increase awareness of CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima has transitioned how we engage with our community partners and is not attending in-person community collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima continues its participation in community collaborative meetings and community events by attending virtual meetings and events; CalOptima also looks for additional ways to support our community partners by providing CalOptima informing materials and, if requested and criteria are met, by providing branded items. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers were provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events, provided the future event(s) meet the criteria set forth in Policy AA.1223 and meets eligibility requirements indicated by Board of Directors.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

March

Date and Time	Event Title	Event Type/Audience	Staff/Volunteer/ Financial Participation	Location
Tuesday, 3/2 9:30–11 a.m.	++ Collaborative to Assist Motel Families Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 3/2 9:00–10:30 a.m.	*Cafecito Meeting	Steering Committee Meeting: Open to Collaborative Members	3 Staff	Virtual format
Wednesday, 3/3 10 a.m.–12 p.m.	++ Anaheim Human Services Network Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 3/4 9–11 a.m.	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 3/4 11 a.m.–1 p.m.	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 3/8 1–2:30 p.m.	++Orange County Veterans and Military Families Collaborative - Children and Families Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 3/8 2:30–3:30 p.m.	++Fullerton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 3/9 10–11:30 a.m.	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 3/9 3:30–5:30 p.m.	++Wellness and Prevention Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 3/10 12–1:30 p.m.	++Anaheim Homeless Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format

Thursday, 3/11 10:00–11:30 a.m.	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 3/11 11:30 a.m.–12:30 p.m.	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 3/11 12:30–1:30 p.m.	++Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Thursday, 3/11 3:30–5:30 p.m.	++State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Friday, 3/12 9–11 a.m.	++Senior Citizens Advisory Council General Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 3/15 1–4 p.m.	++ OCHCA Mental Health Services Act Steering Committee Meeting	++ OCHCA Mental Health Services Act Steering Committee	1 Staff	Virtual format
Tuesday, 3/16 8:30–10 a.m.	++ North Orange County Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 3/16 11 a.m.–12 p.m.	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 3/16 1-2:30 p.m.	++Aging and Disability Resource Connection Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 3/17 9–10:30 a.m.	++ Covered Orange County Steering Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Wednesday, 3/17 11 a.m.–12 p.m.	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 3/17 3:30–4:30 p.m.	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call

Thursday, 3/18 9–11:00 a.m.	*Health Network Forum	Health and Human Service Providers	10+ Staff	Virtual format
Monday, 3/22 12:30–1:30 p.m.	++Stanton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 3/23 9–10:30 a.m.	++Clinic in the Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 3/25 1:30–3:30 p.m.	++ Orange County Care Coordination for Kids Meeting	Steering Committee Meeting: Open to Collaborative Members	2 Staff	Virtual format

Continued to a Future Meeting

CalOptima Board Action Agenda Referral

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

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

Contacts
Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions
1. Adopt CalOptima's 2021–2022 Legislative Platform; and
2. Authorize the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the 2021–2022 Legislative Platform and provide regular progress reports to the Board of Directors.

Background
As part of its Government Affairs program, CalOptima staff track and analyze state and federal legislation that may impact CalOptima and its members, providers and other stakeholders. Staff also engage with federal and state trade associations, federal and state advocates, and elected officials at all levels of government to educate them on how proposed legislation and regulatory guidance may impact CalOptima's interests.

To guide legislative advocacy efforts by staff and better represent CalOptima's interests in Sacramento and Washington, D.C., staff developed a 2021–2022 Legislative Platform (Platform) for consideration by the CalOptima Board of Directors. When drafting the Platform, staff solicited input from CalOptima leadership to ensure public policy objectives reflect current organizational goals, including the 2020–2022 Strategic Plan. In determining whether a public policy objective should be included within the Platform, staff considered whether it was: 1) likely to require or be impacted by legislative action; and 2) likely to be considered by Congress and/or the Legislature in the upcoming legislative sessions.

Discussion
Staff efforts and feedback received identified the following policy priority areas for inclusion in the Platform:

- Response to COVID-19
- California Advancing and Innovating Medi-Cal (CalAIM)
    - Enhanced Care Management and In Lieu of Services
    - Dual Eligible Special Needs Plan
    - Population Health Management
    - Full Integration
- Behavioral Health
- Homeless Health
- Social Determinants of Health (SDOH)
- Telehealth

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- Children's Services
- Senior Services
- Medi-Cal Managed Care: Operations and Administration

The Platform includes a policy statement for each priority area. Pending Board approval is the adoption of the Platform and the authorization for the CEO, or designee, to implement federal and state legislative advocacy efforts that support the policy statements and priority areas outlined in the Platform. Such actions may include executing letters of support and opposition to lawmakers and other government officials on behalf of CalOptima, as well as authorizing formal CalOptima positions on introduced legislation. Any recommendation for a formal CalOptima position on introduced legislation will be brought to the Board for consideration.

Fiscal Impact

The recommended action to adopt CalOptima's 2021–2022 Legislative Platform and authorize associated legislative advocacy efforts are operational in nature. Staff will include any expenses related to this action in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

Legislative advocacy continues to be a priority for CalOptima given the level of activity on health care-related issues in Congress and the State Legislature. Proactive engagement with trade associations, advocates and elected officials is critical to influencing policy decisions that are likely to impact CalOptima. Staff anticipate that several important issues, including COVID-19 vaccine administration, CalAIM implementation, behavioral health reform and expansion of telehealth, will require attention and involvement in the coming two years. Adoption of the 2021–2022 Legislative Platform will enable staff to be more strategic, focused and effective in their advocacy efforts regarding CalOptima's priority areas.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. CalOptima's 2021–2022 Legislative Platform

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Legislative Platform

2021–22

CalOptima
A Public Agency
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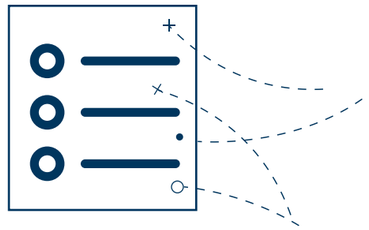

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About CalOptima

Mission

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

Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members

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CalOptima Programs

Medi-Cal (California's Medicaid Program):

For low-income children, adults, seniors and people with disabilities. Most Medi-Cal members have incomes up to 138 percent of the federal poverty level.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan):

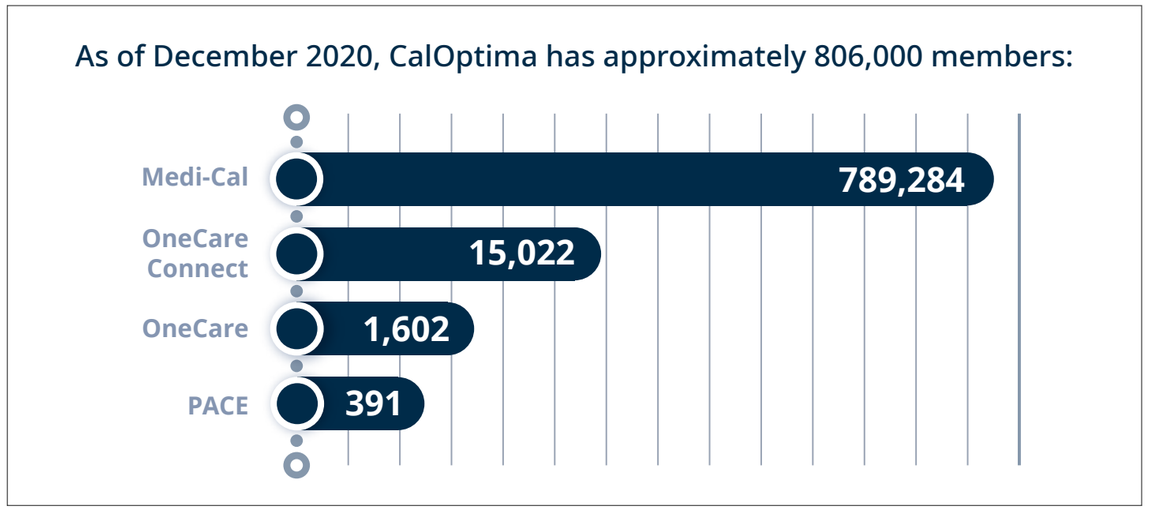
For people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits. Also included are benefits for worldwide emergency care, dental care (through the Medi-Cal Dental Program), vision care and fitness. Other benefits are transportation to medical services and a Personal Care Coordinator. To become a member of OneCare Connect, an individual must be age 21 and older, live in Orange County, have both Medicare Parts A and B and Medi-Cal, and must not be receiving services from a regional center.

OneCare (HMO SNP):

A Medicare Advantage Special Needs Plan (D-SNP), provides comprehensive care for low-income seniors and people with disabilities such as people who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia), and who are dually eligible for Medicare and Medi-Cal. Most of the dually eligible individuals CalOptima serves are enrolled in OneCare Connect, but CalOptima continues to operate OneCare because not all members are eligible for OneCare Connect due to specific federal and state regulatory requirements.

Program of All-Inclusive Care for the Elderly (PACE):

A long-term comprehensive health care program that helps older adults remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. CalOptima PACE has a state-of-the-art facility in Garden Grove, California, that meets the vast majority of participant needs on site, from physical therapy to doctor appointments.



Platform Overview

CalOptima's 2021–22 Legislative Platform reflects the need to be responsive to a wide variety of federal, state and local legislative priorities and issues.

Overview

Federal

The policy landscape, recently shaped by the COVID-19 pandemic, attempts to modify the Affordable Care Act (ACA) and increase access to affordable health care coverage. The transition from the Trump Administration to the Biden Administration in 2021 will also bring change. However, the public health emergency and focus on the ACA are expected to continue for the foreseeable future. The Centers for Medicare & Medicaid Services (CMS) is responsible for setting regulatory policies guiding Medicare and Medicaid, including oversight and federal funding for California's Medi-Cal program, while Congress sets legislative priorities.

State

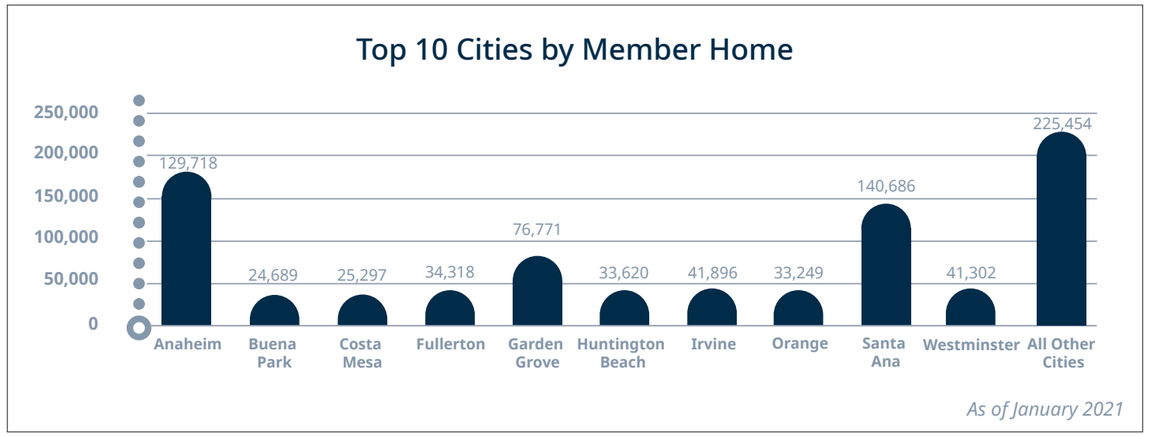
In California, the health policy landscape directly impacts the state's Medi-Cal program. In addition to an ongoing response to the COVID-19 pandemic, the State continues to address issues related to strengthening and transforming the Medi-Cal program. Improving care for California's youth and senior populations, increasing access to behavioral health services, utilizing telehealth, and working to end homelessness are some of the State's top priorities. The California Department of Health Care Services (DHCS) and the State Legislature will continue to shape the future of health care in California during the 2021–22 legislative session.

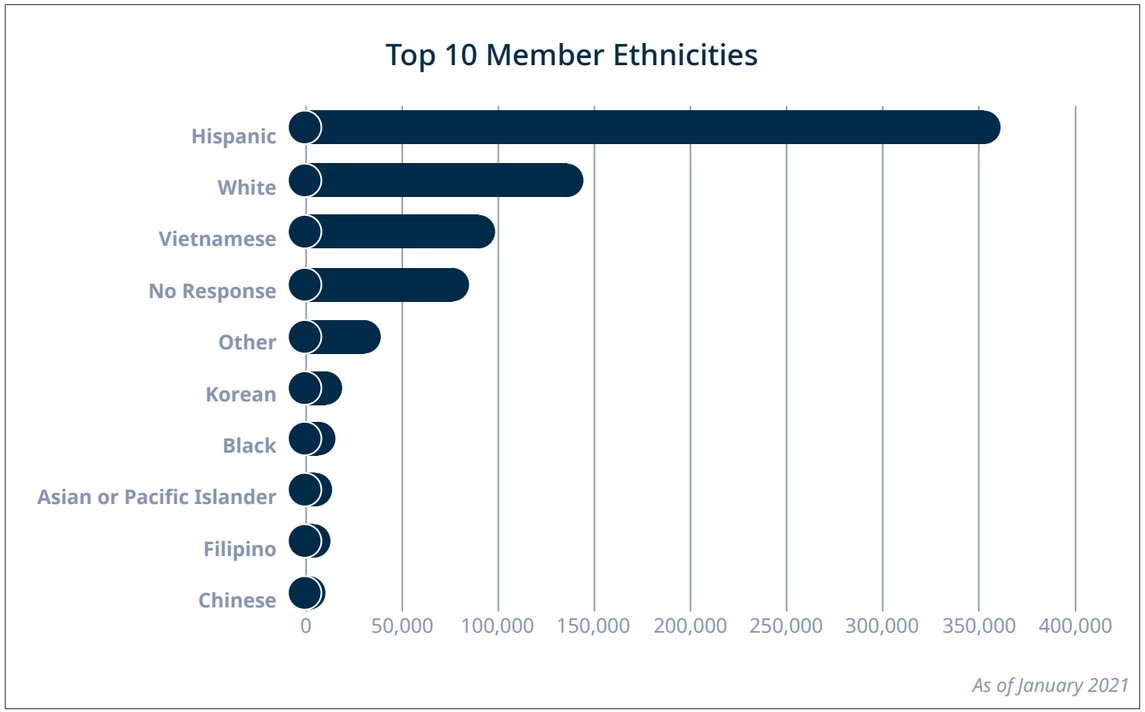
Local

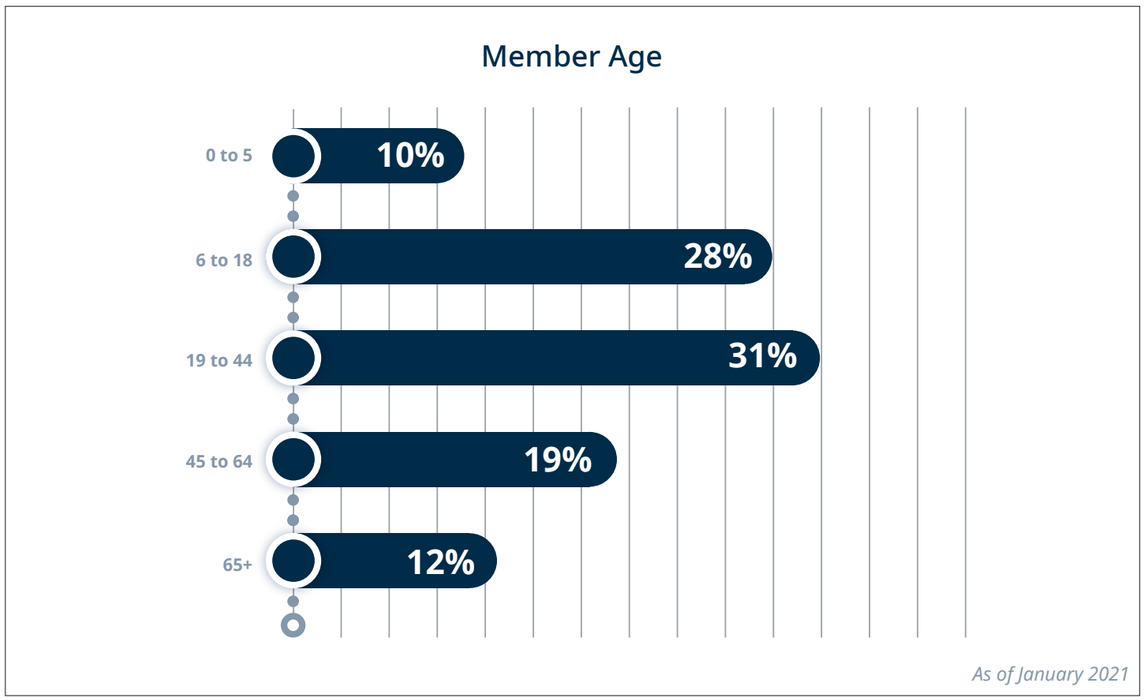
CalOptima is an integral part of the health care sector and business community in Orange County. As the sole Medi-Cal plan in the county, CalOptima is in a unique position to impact care delivery and partner with County agencies and other stakeholders to improve access to quality care for all members. Through advocacy, CalOptima will continue to respond to the COVID-19 pandemic and focus on policy areas such as social determinants of health, telehealth, behavioral health, and homeless health care services.

CalOptima Demographic Information

As a County Organized Health System (COHS), CalOptima is the community-based health plan for Orange County's low-income individuals and families. More than 800,000 people - 1 in 4 Orange County residents - depend on CalOptima for access to health care.







Legislative Priorities

The 2021–22 Legislative Platform focuses on key issues that directly impact Medi-Cal managed care and CalOptima members and stakeholders.

- Response to COVID-19
- California Advancing and Innovating Medi-Cal (CalAIM)
- Behavioral Health
- Homeless Health
- Social Determinants of Health
- Children's Services
- Senior Services
- Medi-Cal Managed Care: Operations and Administration

Note: Because the Legislative Platform is approved early in the legislative process, CalOptima may modify priorities as the session progresses.

Response to COVID-19

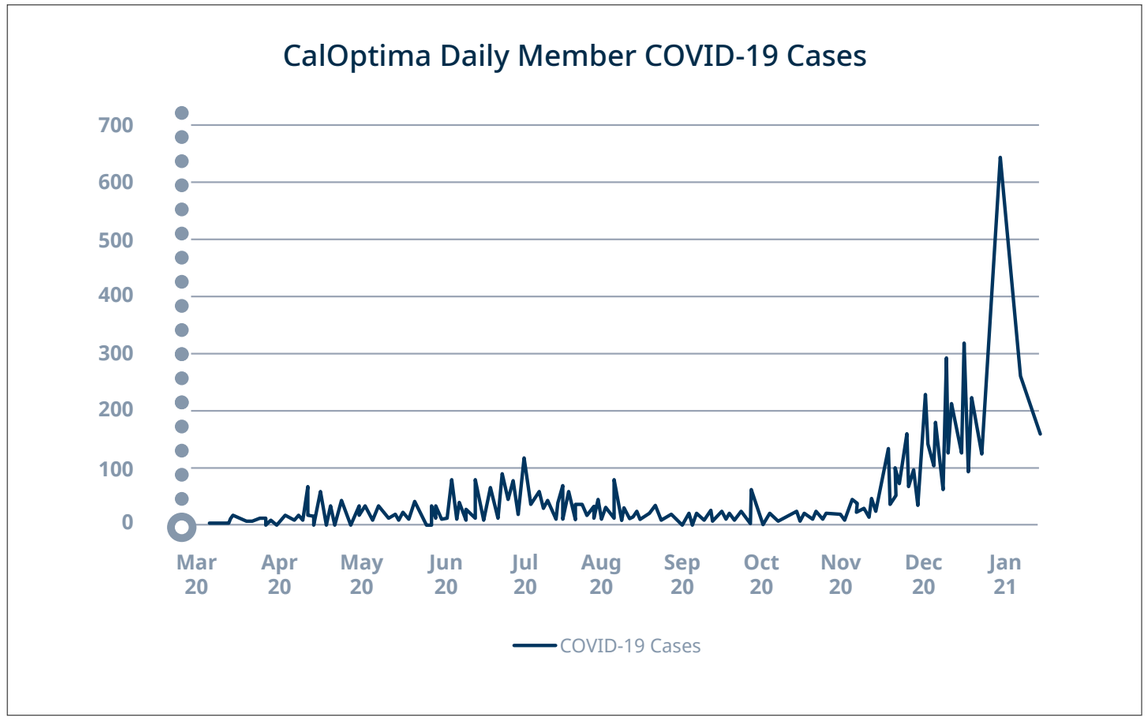
The COVID-19 pandemic has significant health and financial impacts on CalOptima members, providers, health networks and stakeholders. CalOptima members are medically and financially vulnerable, and they overwhelmingly reside in communities that have been hardest hit by the pandemic. As of January 2021, approximately 8,000 CalOptima members have tested positive for COVID-19, 3,400 members have been hospitalized, and nearly 450 members have died. During the public health emergency, CalOptima will continue to play a vital role in closing this health equity gap by ensuring timely, no-cost access to testing, treatment and vaccination for members. Likewise, CalOptima's contracted providers and health networks are critical partners in delivering these services to CalOptima members.

Response to COVID-19

Legislative Actions

Support legislation that advances care, treatment and services related to the COVID-19 public health emergency.

- **Provider Support:** Support efforts to ensure that providers have adequate funding, personal protective equipment and other resources to deliver care and meet members' health needs during the COVID-19 public health emergency.
- **Testing:** Support efforts to ensure that members have equitable access to COVID-19 diagnostic testing services at no cost.
- **Vaccine Distribution:** Support policies to ensure that members have equitable access to COVID-19 vaccines in a timely manner and at no cost, and that plans have access to vaccine administration data.



California Advancing and Innovating Medi-Cal (CalAIM)

On January 8, 2021, DHCS released its formal proposal for CalAIM, a multiyear initiative to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reforms. While the COVID-19 pandemic delayed the 2020 CalAIM proposal, Governor Newsom's Proposed State Budget includes $1.1 billion for Fiscal Year (FY) 2021–22 and $1.5 billion for FY 2022–23 to implement CalAIM.

CalAIM

Legislative Action

Support legislation and regulatory policies and proposals for CalAIM initiatives that benefit CalOptima's members.

Enhanced Care Management and In Lieu of Services

The Whole-Person Care (WPC) program was authorized by CMS and DHCS as a pilot program within the Medi-Cal 2020 Waiver. Orange County's WPC program focuses on Medi-Cal members experiencing homelessness. Shortly after the launch of WPC, CalOptima launched Phases 1 and 2 of the Health Homes Program (HHP), which promotes access to the full range of physical, behavioral and social services for members with complex needs. California plans to incorporate segments of the WPC and HHP programs into CalAIM and transition these pilot programs into new statewide benefits that provide a broader platform for Medi-Cal members. In partnership with the Orange County Health Care Agency and community-based organizations, CalOptima is exploring proposals within CalAIM's Enhanced Care Management and In Lieu of Services initiatives.

Legislative Actions

- **Enhanced Care Management (ECM)**
  - → Support legislation and regulatory policies regarding ECM services, including the clarification of eligible populations.
- **In Lieu of Services (ILOS)**
  - → Support legislation and regulatory policies regarding ILOS services, including the clarification of eligible populations.
  - → Support legislation and regulatory policies to ensure ILOS program outcomes are in alignment with ECM, WPC, and HHP.

Dual Eligible Special Needs Plan

OneCare Connect (OCC) is CalOptima's Cal MediConnect program that combines Medicare and Medi-Cal benefits into one health plan. Due to delivery system carve-outs, Cal MediConnect plans were never able to integrate the full range of Medi-Cal benefits. Since CalOptima launched OCC as a pilot program on July 1, 2015, it has been extended over the years by both state and federal authorities. However, it is currently scheduled to end on December 31, 2022. CalAIM proposes to transition members into Dual Eligible Special Needs Plans (D-SNP) by January 1, 2023. CalOptima is evaluating the impact of moving approximately 14,700 OCC members into OneCare, CalOptima's D-SNP. Additionally, the CalAIM proposal has yet to determine if CMS or the plans will manage the transition of members into a D-SNP.

Legislative Action

- **Dual Eligible Special Needs Plans:** Advocate for plan flexibility to allow CalOptima to directly manage a seamless transition of beneficiaries from OneCare Connect to OneCare.

Population Health Management

In 2019, CalOptima adopted a Population Health Management (PHM) strategy as a comprehensive plan of action to address the needs of its culturally diverse membership in an equitable, holistic manner. The PHM strategy focuses on keeping members healthy, managing members with emerging risks and/or multiple chronic conditions, and improving patient safety and outcomes across all settings.[1] Because Medi-Cal managed care plans are not currently mandated to have a PHM strategy, DHCS has proposed requiring whole system, person-centered PHM strategies with standardized requirements across plans, including the implementation of wellness, prevention, case management and care transition programs.

Legislative Action

- **Population Health Management:** Support policies and funding that promote wellness, prevention and health equity.

Full Integration

DHCS plans to pilot the full integration of physical health, behavioral health and oral health under one contracted entity in a county or region. This would require multiple Medi-Cal delivery systems, including Medi-Cal managed care, county mental health plans and county Drug Medi-Cal Organized Delivery Systems, to be consolidated under one contract with DHCS. While few details have been considered or released, it is imperative that CalOptima plays a proactive role in the development of any integration plans, which are likely to have significant impacts on CalOptima operations and the delivery of care for members.

Legislative Actions

- **Coordination of Care:** Support policies that increase care coordination and data sharing across all delivery systems as well as remove barriers to accessing care.
- **Managed Care Benefits:** Oppose policies that would carve out any current managed care plan benefit.

Behavioral Health

Behavioral health reform continues to be a top priority of Governor Newsom, as outlined in his 2020 State of the State Address. Recently, CalOptima and its providers began participating in the two-year Behavioral Health Integration (BHI) Incentive Program. The program, authorized under Proposition 56 Value-Based Payment initiatives, incentivizes the improvement of physical and behavioral health outcomes. CalOptima's behavioral health providers were awarded approximately $13 million for 12 projects.

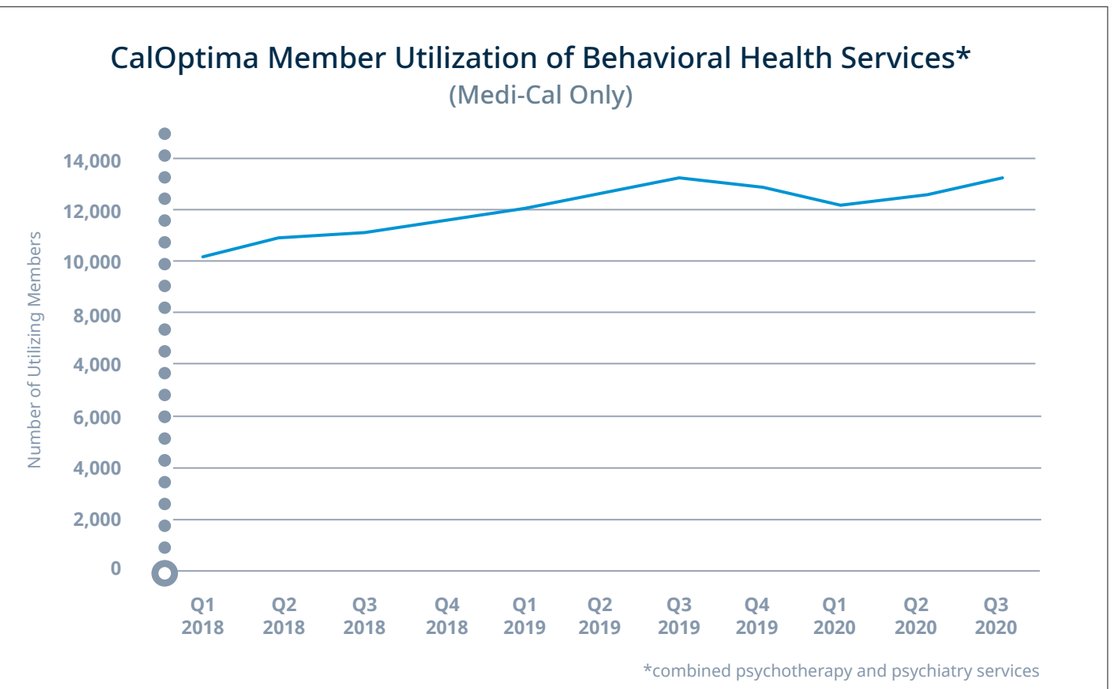
Although the COVID-19 pandemic has delayed progress on many other initiatives, behavioral health continues to be a major focus of legislative and regulatory activity. The utilization of behavioral health services has been increasing for several years. It is anticipated that there will continue to be a long-term increase in demand as a result of the COVID-19 pandemic. At the same time, behavioral health providers continue to opt out of Medi-Cal due to low reimbursement rates. Access to patient information and history continues to be another barrier to quality and timely behavioral health services, and DHCS guidance is needed to facilitate improved data sharing among health care entities. Anticipated legislative and regulatory activity may include but is not limited to: behavioral health payment reform, revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults, administrative behavioral health integration statewide, regional contracting, and substance use disorder managed care program renewal and policy improvements.

Behavioral Health

Legislative Actions

Support legislation and regulatory policies that improve access to and the delivery of behavioral health services.

- **Integration & Coordination of Care:** Support policies that strengthen the coordination of physical and behavioral health needs across delivery systems, including enhanced data sharing between all health care entities.
- **Payment Parity:** Support policies that secure competitive reimbursement rates for behavioral health providers.
- **Value-Based Payment:** Support policies that expand opportunities to implement value-based payment arrangements with health networks and providers.



Prior to the COVID-19 pandemic, utilization of behavioral health services by CalOptima members was steadily increasing. The pandemic has slightly impacted utilization in the short term as some members may be choosing to delay care out of concern with in-person office visits. However, the pandemic is expected to create an increase in demand for behavioral health services over the long term. Please note: this figure includes the most recent data reported, as of January 2021.

Homeless Health

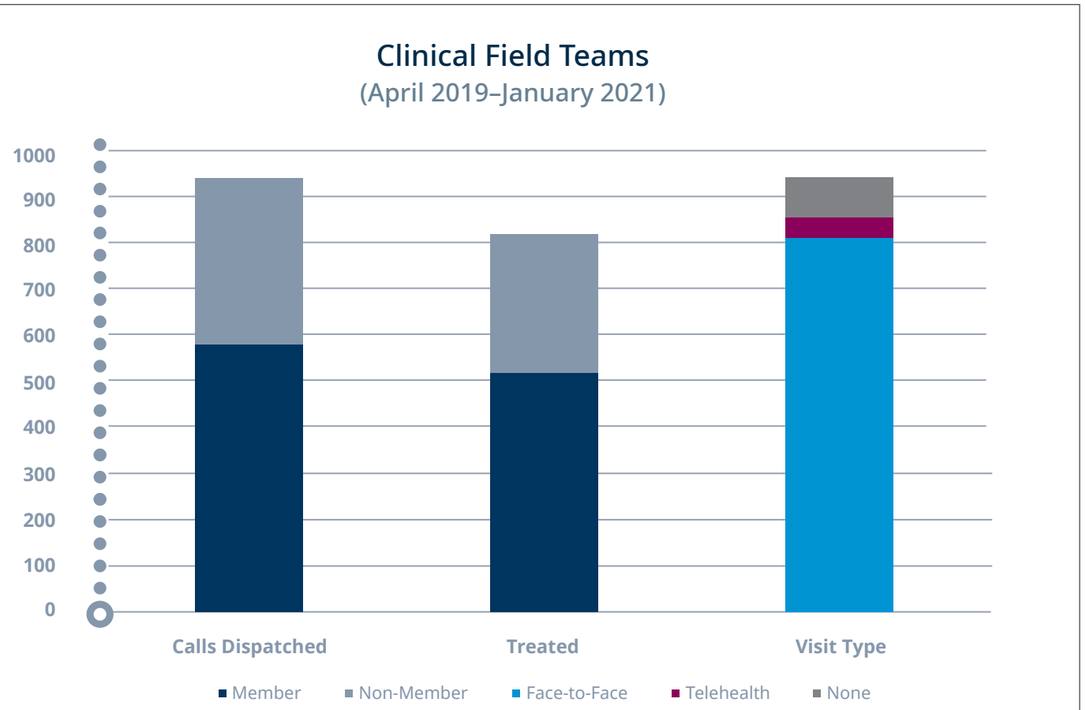
California has the largest number of individuals experiencing homelessness in the nation, with more than 151,000 people living on the streets or in shelters.[2] CalOptima members experiencing homelessness have unique challenges accessing the traditional health care delivery system. In 2019, Orange County's Point in Time Count reported nearly 7,000 individuals experiencing homelessness.[3] In collaboration with the County of Orange, CalOptima committed enhanced funding and Intergovernmental Transfer dollars to make systemic changes, including the launch of Clinical Field Teams and CalOptima's Homeless Response Teams, as well as the expansion of recuperative care. CalOptima intends to explore opportunities to address the health care needs of individuals experiencing homelessness under CalAIM, identifying high-priority areas for response, including the use of mobile clinics.

Homeless Health

Legislative Actions

Support legislation that expands existing homeless health care initiatives.

- **Behavioral Health Services:** Support legislation that increases access to behavioral health and substance use supports and services for those experiencing or at risk of homelessness.
- **Field Teams:** Support legislation that increases access to mobile health care services for those experiencing homelessness.
- **Wrap-around Services:** Support legislation that includes wrap-around services for individuals experiencing homelessness, at risk of homelessness or experiencing housing insecurities, with a goal to provide health support and prevent chronic homelessness (e.g., WPC, ILOS, ECM, etc.).



Data as of January 2021

CalOptima members experiencing homelessness have unique challenges accessing the traditional health care delivery system. In April 2019, CalOptima launched a Clinical Field Team program, sending medical professionals and social workers out into the community to treat homeless individuals where they are. Local community health centers have created dedicated teams, which are on call seven days a week and prepared to travel to any area in Orange County.

Social Determinants of Health

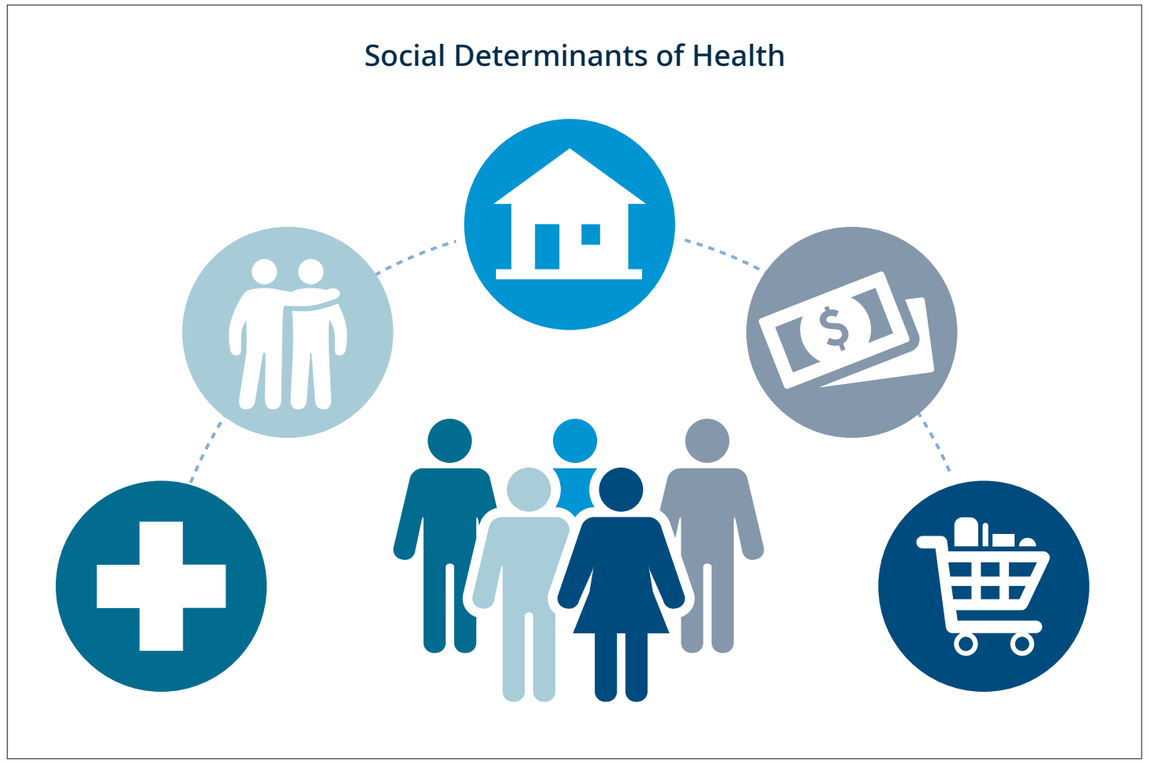
Social determinants of health (SDOH) are social, economic and environmental factors that impact an individual's health and well-being. These factors include but are not limited to hunger, childcare, housing, employment and family life. According to CalOptima's 2018 Member Health Needs Assessment Final Report, SDOH can either facilitate good health or act as barriers. CalOptima members have identified financial stressors, social isolation and safety concerns as significant factors affecting their health.[4] In response to these findings, CalOptima has taken steps to strengthen the safety net for members by expanding access to primary care services and releasing community grants to support programs addressing the SDOH of our members. This includes expanded efforts to help providers and community partners better understand SDOH and adapt health care services appropriately.

Social Determinants of Health

Legislative Actions

Support Medi-Cal funding for non-medical services that address SDOH.

- **Food Insecurity:** Support funding and policies that address food insecurity, in partnership with community organizations.
- **Housing and Infrastructure:** Support legislation that advances the development of supportive housing, crisis stabilization units and health care facilities, including addressing potential barriers created by the California Environmental Quality Act (CEQA).
- **Nutrition:** Support funding for healthy food items, with a physician order, to promote health and wellness.



Telehealth

On March 16, 2020, in response to the COVID-19 pandemic, DHCS expanded access to telehealth services to ensure providers can deliver medically necessary health care services in a timely fashion for beneficiaries impacted by COVID-19.[5]

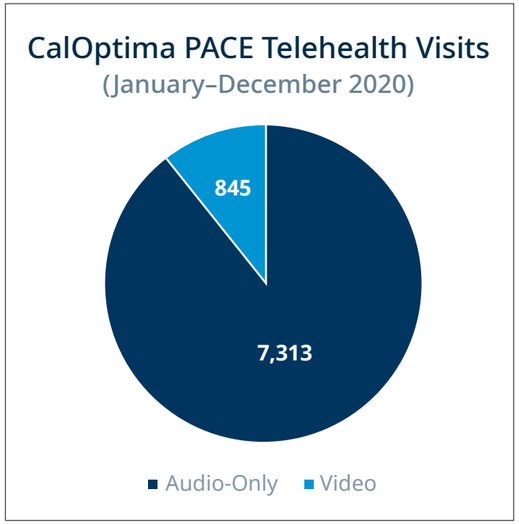
Temporary flexibilities, such as virtual assessments and audio-only telehealth calls, have contributed to an increase in access to providers and use of telehealth services. As a result, the number of CalOptima members who used telehealth services increased by 56,000 percent. In 2019, only 212 CalOptima members used telehealth compared with 120,718 members in 2020.

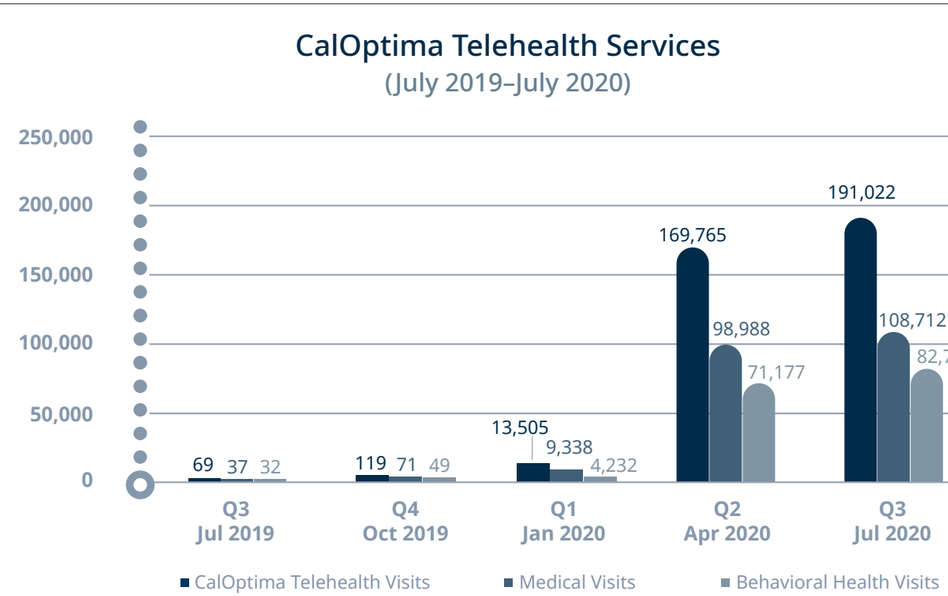
Telehealth

Legislative Actions

Support legislation and regulatory policies that expand access to telehealth services.

- **Flexibilities:**
  - → Support legislative and regulatory policies that continue the ability to conduct virtual assessments and audio-only telehealth services post COVID-19.
  - → Support equity by applying the same telehealth requirements for providers' offices, Federally Qualified Health Centers and Rural Health Clinics.
  - → Support the ongoing establishment of new patients via telehealth services.
  - → Support both traditional telehealth and other virtual/telephonic communication modalities to help ensure access to care for members.
- **Payment Parity:**
  - → Advocate for clarification of the difference in cost of care for delivering in-person services and telehealth services.





Please note: this figure includes the most recent data reported, as of January 2021.

Children’s Services

CalOptima’s youth members are eligible to receive routine preventive care services, such as well-child visits; dental, vision and hearing care; behavioral health care and trauma screenings; and vaccinations. As of December 2020, there are approximately 310,000 CalOptima members who are under the age of 19. This includes 12,000 children with certain health conditions who receive care through the Whole Child Model program. Additionally, children under the age of 19 are eligible for full-scope Medi-Cal, regardless of immigration status, if their families meet the income standards. CalOptima remains dedicated to providing coordinated, person-centered care for its youngest members.

Children’s Services

Legislative Actions

Support legislation that increases access to and the quality of care for CalOptima’s youth members.

- **Adverse Childhood Experiences (ACEs):** Support legislation to allow Medi-Cal reimbursement for non-traditional trauma-informed services.
- **Behavioral Health (BH) in Response to COVID-19:** Support increased incentives and reimbursement for pediatric BH providers, in response to social isolation, distance learning and loss brought upon by the COVID-19 pandemic.
- **Developmental Disabilities:** Support legislative and budget proposals that improve the quality of care for CalOptima members living with a developmental disability.

Senior Services

As of December 2020, CalOptima has nearly 96,000 members age 65 and older. CalOptima and its community partners provide person-centered care to older adults and seniors in need of complex care. This includes providing greater access to skilled care, increasing awareness for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) Center, responding to the COVID-19 pandemic, and by facilitating transitions from a medical setting to a home-based setting. Implementing a person-centered care system may include the coordination of physical health, oral health, mental health, cognitive health, and Long-Term Services and Supports (LTSS), in addition to promoting full access and health equity.

Senior Services

Legislative Action

Support legislation and regulatory policies that increase access to and the quality of care for CalOptima's older adult members.

- **Congregate Living Settings:** Support legislative policies and funding opportunities for programs that address the spread of infectious diseases in congregate living settings, such as skilled nursing facilities and long-term care centers.
- **Home- and Community-Based Services (HCBS):**
  - → Support ongoing funding for HCBS, including Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), LTSS and In-Home Supportive Services (IHSS).
  - → Support legislative and regulatory policies that promote successful aging in place, ensuring older adults can remain safely in their homes.
- **LTSS:** Support legislative policies that promote the coordination of physical health, oral health, mental health and cognitive health for CalOptima members receiving LTSS.
- **Master Plan for Aging (MPA):** Support legislative policies and proposals that advance the MPA, a statewide blueprint that promotes and supports successful aging, and leverage Medicare to provide additional long-term services and supports for CalOptima's older adult population.
- **PACE**
  - → Support legislative priorities sponsored by CalPACE and the National PACE Association to increase awareness of, access to and utilization of PACE.
  - → Support regulatory policies that would expand services to additional at-risk populations, including individuals with severe mental illness and younger adults with physical disabilities.

Medi-Cal Managed Care: Operations and Administration

California's Medi-Cal program is the largest state Medicaid program in the nation, insuring almost one-third of California's more than 38 million residents.[6] In 2014, California opted to expand Medi-Cal eligibility under the Affordable Care Act, significantly increasing the number of Medi-Cal beneficiaries overall and in managed care plans. With both the California Department of Managed Health Care and DHCS providing Medi-Cal oversight, there are myriad legislative issues, such as Knox-Keene licensure, Medicaid funding and health equity, that may have a direct impact on managed care plans.

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Medi-Cal Managed Care: Operations and Administration

Legislative Action

Support legislation and regulatory policies that benefit CalOptima and the County Organized Health System (COHS) model.

- **Affordable Care Act:** Support policies that uphold and maintain the Affordable Care Act.
- **Knox-Keene Act:** Oppose legislation that would require COHS plans to obtain a Knox-Keene license.
- **Medicaid Funding:** Oppose legislative and budget proposals that would reduce Medicaid funding at the federal and state levels, resulting in the elimination of optional benefits or other Medicaid programs.
- **Proposition 56:** Support legislative and budget proposals that continue Proposition 56 directed payments but modify the Value-Based Payment Program to ease administrative burden by using HEDIS (Healthcare Effectiveness Data and Information Set) measure definitions, specifications and physician practices.

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About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions regarding the above information, please contact **GA@caloptima.org**

Endnotes

[1] CalOptima: Population Health Management (PHM) Strategy, February 2019
[2] Center for Health Care Strategies: California Health Care and Homelessness Learning Community, September 2020
[3] County of Orange: Orange County's 2019 Sheltered Point In Time Count, October 2019
[4] CalOptima: Member Health Needs Assessment Final Report, March 2018
[5] Department of Health Care Services, Medi-Cal Payment for Medical Services Related to the 2019-Novel Coronavirus (COVID-19), March 16, 2020
[6] Medi-Cal Managed Care: An Overview and Key Issues, Kaiser Family Foundation, March 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

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

Recommended Actions

1. Authorize a temporary, short-term supplemental Medi-Cal payment increase of 5% from current levels to certain Providers affiliated with Providence St. Joseph Heritage Healthcare for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and
2. Authorize the additional 5% unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

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 (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for certain providers affiliated with Providence St. Joseph Heritage Healthcare is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support certain providers affiliated with Providence St. Joseph Heritage Healthcare and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for

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other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to certain providers affiliated with Providence St. Joseph Heritage Healthcare for identified services through the claims payment system. Staff will give notice to certain providers affiliated with Providence St. Joseph Heritage Healthcare of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to certain providers affiliated with Providence St. Joseph Heritage Healthcare monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels to certain providers affiliated with Providence St. Joseph Heritage Healthcare is an unbudgeted item.

The projected aggregated fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal fee-for-service providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for St. Joseph Heritage Healthcare is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthen access to member care and support the safety net system serving CalOptima members during the pandemic.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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Attachment 1: Services Excluded from Temporary, Short-Term Supplemental Payment Increase

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses

Contacts

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

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and

2. Authorize the additional 5% in unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

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 (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support CalOptima's Medi-Cal FFS providers and strengthen access to care,

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given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

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Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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Attachment 1: Services Excluded from Temporary, Short-Term Supplemental Payment Increase

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into amendments to the Program of All-Inclusive Care for the Elderly (PACE) and Multipurpose Senior Services Program (MSSP) non-medical ancillary Fee-For-Service (FFS) provider contracts to reflect standardized payment rates to be effective on or after March 4, 2021; and
2. Authorize the CEO to develop and implement standardized payment rates for PACE and MSSP non-medical ancillary FFS provider contracts.

Background

CalOptima currently contracts with ancillary provider types to provide covered, non-medical services on a fee-for-service (FFS) basis to CalOptima members in the PACE and MSSP programs. These contracts are extended to providers who successfully meet all CalOptima credentialing and participation requirements per policy.

For those PACE and MSSP program providers of non-medical covered services whose rates are not represented in the published Department of Health Care Services (DHCS) Medi-Cal or Centers for Medicare & Medicaid Services fee schedules, CalOptima has historically utilized varying rates within provider categories at different periods of time. CalOptima staff has reviewed the 2019 report from the National PACE Association which addresses personal home care costs for PACE centers in the community and has determined that CalOptima's PACE costs for personal home care services are at the lowest range, resulting in the need to adjust non-medical ancillary provider services rates for adequate access to these services. Staff believes that updating and standardizing rates is necessary to sustain and expand access to non-medical ancillary services in the PACE and MSSP provider networks.

Discussion

CalOptima seeks to ensure continued access for PACE and MSSP members to a comprehensive network of non-medical ancillary providers of covered, vital services allowing these members to remain safely in their homes. In support of CalOptima's non-medical ancillary network, staff believe it is necessary to standardize reimbursement rates for equitability for providers by service type. To determine the appropriateness of the updated rates, staff assessed the reimbursement rates utilized by other PACE and MSSP sites in the Southern California region. The services provided by non-medical ancillary providers include:

- Personal care and chores

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- Delivered meals
- Emergency response equipment
- Repair technicians to install and repair equipment needed to aid disabled members

Approval of provider reimbursement rates includes annual Board of Directors' budget approval for each program using prior period claims data to forecast overall utilization and claims expenses. Within this process, staff requests authority to update reimbursement terms to reflect standardization of rates for PACE and MSSP non-medical ancillary providers rendering authorized covered services in members' homes to align with other MSSP and PACE sites in the region.

Fiscal Impact
The recommended action to standardize reimbursement rates for certain non-medical PACE and MSSP ancillary providers is an unbudgeted item. The projected aggregate annual fiscal impact is approximately $385,000 or 31.2%. The projected aggregate Fiscal Year (FY) 2020-21 fiscal impact is approximately $129,000.

Specifically, the rate adjustment for the PACE program has an annual fiscal impact of approximately $368,000 or $123,000 through June 30, 2021. The rate adjustment for the MSSP program has an annual fiscal impact of approximately $17,000 or $6,000 through June 30, 2021.

Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal and PACE programs in the current fiscal year will be sufficient to support the additional costs in unbudgeted rate adjustments.

Rationale for Recommendation
Updating and standardizing rates for CalOptima PACE and MSSP non-medical ancillary providers providing covered services to CalOptima members will create equitable reimbursement within provider types, helping ensure access to critical services for CalOptima PACE and MSSP members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Attachment 1_Previous Board Action dated April 2, 2020: "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."

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
A-1 Healthcare Management, Inc., dba A-1 Home Health Care	5011 Argosy Ave., Ste. 4	Huntington Beach	CA	92649
Cambrian Homecare	5199 E. Pacific Coast Highway, Ste. 100	Long Beach	CA	90804
Care Dimensions, LLC	3130 S. Harbor Blvd. Ste. 270	Santa Ana	CA	92704
HHCSC, Inc. dba All Valley Home Care	17272 Newhope St., #J1	Fountain Valley	CA	92708
GTL Incorporated, dba Link to Life	22600 Haggerty Road	Farmington	MI	48335
S&O Care Services, dba Homewatch Caregivers	8175 Kaiser Blvd. Ste. 217	Anaheim	CA	92808
St. Joseph Health Personal Care Services, LLC, dba Nurse Next Door	200 W. Center Street Promenade	Anaheim	CA	92805

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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

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

Contact

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

Recommended Action(s)

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 | Amended 4/2/2020

Background/Discussion

CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service (FFS) basis to CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval. CalOptima also contracts on a capitated administrative fee basis (with the administrator passing the medical costs through to CalOptima on a FFS basis) with MedImpact ~~for~~ for Pharmacy Benefit Management (PBM) services, and with VSP for vision-related services.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE Ancillary contracts, and contracts with MedImpact and VSP, through June 30, 2021.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted ancillary provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The recommended action to extend CalOptima ancillary contracts through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the ancillary provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated February 6, 2020; Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services
2. Board Action Dated August 1, 2019; Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc.to Extend the Contract

/s/ Michael Schrader *03/26/2020*

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of an Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services

Contact
Kristin Gericke, Director, Clinical Pharmacy Management (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations (714) 246-8400

Recommended Action
Ratify Amendment to CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services, to revise prescription drug rebate provisions for CalOptima's Medi-Cal line of business.

Background
On May 7, 2015, the CalOptima Board of Directors (Board) authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options.

On October 4, 2018, the Board authorized an amendment to the PBM agreement by exercising CalOptima's first one-year extension option through December 31, 2019.

On February 7, 2019, the Board ratified revisions to the PBM agreement to include the collection of prescription drug rebates for CalOptima's Medi-Cal program.

More recently, on August 1, 2019, the Board authorized an amendment to the PBM agreement to extend the term through December 31, 2021.

Discussion
Pursuant to the primary agreement with the California Department of Health Care Services (DHCS), CalOptima had participated in the State Pharmacy Rebate program by submitting all pharmacy claims to DHCS on a monthly basis. DHCS, in turn, had managed collection of pharmacy rebates on an aggregate basis for all County Organized Health System (COHS) plans statewide.

With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, Medi-Cal managed care organizations became eligible to collect drug rebates for covered outpatient drugs dispensed to Medi-Cal members. The ACA made drug rebates applicable to both pharmacy-dispensed outpatient drugs and physician administered drugs. In addition, California statutory language restricting the COHS plans' ability to negotiate supplemental rebates with drug manufacturers was also removed via enactment of Senate Bill (SB) 870 on June 20, 2014, enabling COHS plans to negotiate rebates with drug manufacturers.

During its rate development meeting on October 25, 2018, DHCS informed CalOptima that the collection of prescription drug rebates by Medi-Cal managed care plans had gone from being optional to

mandatory, and instructed CalOptima to make commensurate adjustments to its reported cost data to DHCS.

As such, CalOptima, together with MedImpact, developed a contract amendment to implement a prescription drug rebate program. The contract amendment provided rebates per paid claims. This payment rate includes rebate management services and increases the amount to $4.50 per paid claim. Although the amendment, effective June 1, 2019, included provisions for collection of prescription drug rebates for all paid claims, CalOptima was subsequently informed by MedImpact that, for the Medi-Cal line of business, rebates are only applicable to claims for diabetic test strips and those drugs for which a manufacturers' rebate is available.

Staff therefore subsequently amended CalOptima's agreement with MedImpact to clarify that, effective October 1, 2018, rebates will only apply to Medi-Cal claims for diabetic test strips and medications that qualify for a manufacturers' rebate (i.e., MedImpact pays CalOptima a minimum rebate guarantee of $4.50 per claim only for claims for diabetic test strips and those drugs for which a manufacturers' rebate is available—not for all Medi-Cal medications). The projected amount of rebate dollars collected is also being revised pursuant to this change to include only those claims.

Staff seeks ratification of this amendment to the MedImpact PBM contract effective June 1, 2019, to include updated language clarifying which claims are eligible for rebates.

Fiscal Impact

The recommended action to ratify an amendment to CalOptima's contract with MedImpact for PBM services clarifies that the prescription drug rebate provisions for the Medi-Cal line of business is not expected to have an additional fiscal impact on the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. Staff projects approximately $1.8 million for FY 2018-19 and $3.2 million for FY 2019-20 in prescription drug rebates.

Generally, revenue from rebates would decrease prescription drug costs in the short term, but such cost savings would be offset by a commensurate decrease in future Medi-Cal revenue. With the Governor's Executive Order N-01-019 to transition most Medi-Cal pharmacy services from managed care to fee-for-service (FFS) by January 1, 2021, DHCS is expected to adjust CalOptima's Medi-Cal revenue for pharmacy services accordingly in the future. While pharmacy services remain a managed care benefit, Staff plans to include PBM fees and potential rebates in future operating budgets. In addition, Staff will monitor pharmacy expenses and rebates prior to and during the transition period to Medi-Cal FFS.

Rationale for Recommendation

The above recommendation will provide clarification regarding applicability of rebates under CalOptima's MedImpact agreement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entity Covered by this Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated February 7, 2019, Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services
5. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

Attachment to February 6, 2020 Board of Directors Meeting – Agenda Item 10

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
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Information Processing System	125
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Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
7. Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services

Contact
Kristin Gericke, Director, Pharmacy Management, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action
Ratify amendment of CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services to begin collecting Medi-Cal prescription drug rebates for utilization incurred effective October 1, 2018.

Background
At its May 7, 2015 meeting, the CalOptima Board of Directors (Board) authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options.

On October 4, 2018, the Board ratified extending the PBM agreement by exercising CalOptima's first one-year extension option through December 31, 2019. Under the provisions in the PBM agreement, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. In addition, MedImpact handles rebates for CalOptima's OneCare and OneCare Connect programs. However, CalOptima's agreement with MedImpact does not currently include the collection of prescription drug rebates for CalOptima's Medi-Cal program.

Discussion
Pursuant to the primary agreement with the California Department of Health Care Services (DHCS), CalOptima has participated in the State Pharmacy Rebate program by submitting all pharmacy claims to DHCS on a monthly basis. DHCS, in turn, has managed collection of pharmacy rebates on an aggregate basis for all County Organized Health System (COHS) plans statewide. Initially, the rebate program was implemented when the majority of Medi-Cal enrollees were in Fee-For-Service (FFS) arrangements, and DHCS was able to execute substantial rebate agreements with drug manufacturers for Medi-Cal covered drugs. The understanding was that COHS plans would not execute such agreements for drugs on the Medi-Cal Contract Drug List (CDL), so that DHCS could claim rebates for the drug products listed on the CDL and utilized by the COHS plans.

With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, Medi-Cal managed care organizations became eligible to collect drug rebates for covered outpatient drugs dispensed to Medi-Cal members. The ACA made drug rebates eligible for both pharmacy-dispensed outpatient drugs and physician administered drugs. In addition, California statutory language restricting the COHS plans' ability to negotiate supplemental rebates with drug manufacturers was

removed by the enactment of Senate Bill (SB) 870 on June 20, 2014. The bill enabled COHS plans to negotiate rebates with drug manufacturers, with the understanding that DHCS will continue to submit plans' utilization when invoicing their supplemental contracts with drug manufacturers. In November 2015, DHCS sent additional guidance clarifying that:

> "if a COHS plan chooses to contract for medications currently contracted for by DHCS and listed on the CDL, they may do so…However, if a COHS plan successfully negotiates a supplemental rebate agreement with a drug manufacturer, then the Plan must notify DHCS and the department can no longer use the utilization for that drug (or drugs) when invoicing the manufacturers."

However, guidance provided by DHCS addressing the timeframe to implement SB 870 remained ambiguous. Language in the guidance stated:

> "the language that has always been in effect remains in effect for the time being…It will not become operational until the department officially implements the contracts applicable to both FFS and managed care drug formularies…That will not happen for quite some time."

As such, Medi-Cal managed care plans were aware of their eligibility to begin collecting rebates, but were uncertain when to begin implementation of such actions. Given this uncertainty, Management opted to maintain the existing operational procedures, whereby DHCS continued to collect drug rebates at the state level, until additional direction was given by the State.

At the rate development meeting on October 25, 2018, DHCS informed CalOptima that the collection of prescription drug rebates by Medi-Cal managed care plans was no longer optional, but required, and instructed CalOptima to make commensurate adjustments to their reported cost data to DHCS. By collecting rebates, plans will reduce their prescription drug costs by the amount of the rebates. However, savings to a plan's prescription drug expenses would be offset by a commensurate reduction in state revenue to the plan, since DHCS employs a cost-based methodology to develop a managed care plan's capitation rates.

As such, CalOptima began working with MedImpact on a contract amendment to implement a prescription drug rebate program. Staff has come to agreement with MedImpact on rates and contract terms and is working on a contract amendment to incorporate Medi-Cal prescription drugs within the existing rebate program already covered by the CalOptima-MedImpact agreement. The contract amendment replaces Exhibit B "Fee Schedule" with a guaranteed rebate per paid claim. This payment rate includes rebate management services, and increases to $4.50 per paid claim for Claim Years 4 and 5. Upon receiving Board authorization, Staff anticipates the collection of rebates to begin one hundred twenty (120) days after the end of the preceding quarter, for utilization incurred effective October 1, 2018, and thereafter until such time as the state provides the COHS plans with additional guidance on the Medi-Cal prescription drug benefit.

Fiscal Impact

The recommended action to amend CalOptima's contract with MedImpact for PBM services to collect prescription drug rebates for utilization incurred October 1, 2018, and after is projected to generate

$20.6 million in rebate dollars in Fiscal Year 2018-19, and $27.5 million on an annual basis. While the rebates effectively serve to decrease prescription drug costs, Staff anticipates that the cost savings will be offset by a commensurate decrease in future Medi-Cal revenue.

Rationale for Recommendation

The recommended action will allow CalOptima to comply with the DHCS's requirement for Medicaid managed care plans to collect prescription drug rebates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
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Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
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Catamaran	1,069
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Navitus	1,056
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Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute a new Memorandum of Understanding (MOU) with the County of Orange Social Services Agency (County SSA) for coordination of services between Orange County In-Home Supportive Services (County IHSS) and CalOptima Long-Term Services and Supports (LTSS).

Background
Following the Coordinated Care Initiative (CCI) legislation that went into effect in July 2012, the CCI program was implemented in eight California counties, including Orange County. The two major components of CCI were:

- The implementation of Cal MediConnect, a program that coordinates medical, behavioral health, long-term institutional, and home and community-based services for dual eligible beneficiaries through a single organized delivery system; and
- The addition of Managed Long-Term Services and Supports (MLTSS), including In-Home Supportive Services (IHSS), as a Medi-Cal and Cal MediConnect benefit

More recently, effective January 1, 2018, IHSS was removed as a Medi-Cal and Cal MediConnect benefit, although the Department of Health Care Services (DHCS) conveyed its expectation that each managed care plan (MCP) participating in CCI (including CalOptima) continue to coordinate IHSS with its local Social Services Agency.

Discussion
On December 22, 2017, DHCS released a new IHSS MOU template that was intended to assist CCI counties and MCPs in their collaboration. Since then, CalOptima and County SSA staff have worked in partnership to develop a new MOU that aligns with DHCS's expectations for collaboration and reflects the needs of IHSS consumers in Orange County. While the CalOptima Board of Directors approved moving forward with this approach, the new MOU between CalOptima and the County SSA has not yet been finalized due to various factors preventing County SSA from working on it.

In early 2020, County SSA was able to move forward with development of the MOU on the condition that it be prepared on the County SSA's MOU template versus the DHCS's IHSS MOU template. CalOptima Regulatory Affairs staff has confirmed with DHCS that, while it strongly encouraged use of its template, use of the DHCS template is not required in this situation. Ongoing operational meetings between CalOptima and County SSA have taken place since then to discuss details regarding the

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coordination of services and information sharing between the two entities so that County SSA may proceed with drafting the MOU. A new MOU that County SSA has prepared based on those discussions is under review. Pending its approval, staff seeks authority to enter into the new MOU with the County of Orange for coordination of services between County SSA and CalOptima LTSS.

Fiscal Impact
The recommended action to execute a new MOU with the County SSA for coordination of services between County IHSS and CalOptima LTSS has no fiscal impact.

Rationale for Recommendation
Executing the new MOU with the County of Orange will align CalOptima's efforts with the DHCS directive regarding coordination of IHSS services between MCPs and local public authorities.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action dated March 1, 2018: "Consider Authorizing Memoranda of Understanding with the County of Orange Social Services Agency Related to In-Home Supportive Services"

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Social Services Agency	744 Eckhoff St.	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
13. Consider Authorizing Memoranda of Understanding with the County of Orange Social Services Agency Related to In-Home Support Services

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

Recommended Action
Authorize and direct the Chief Executive Officer, with the assistance of legal counsel, to execute a new Memoranda of Understanding (MOU) with the County of Orange Social Services Agency (SSA) to reflect changes to In-Home Support Services (IHSS) care coordination that became effective January 1, 2018.

Background/Discussion
In July 2012, Governor Brown signed legislation authorizing the Coordinated Care Initiative (CCI). The authority was provided in two pieces of legislation: Senate Bills 1008 and 1036. In June 2013, this authority was modified by CCI Trailer Bill (SB 94), with CCI being implemented in eight counties, including Orange County, beginning in April 2014. The CCI is comprised of two major components:

- **Duals Demonstration**: A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system. The Demonstration is now referred to as Cal MediConnect.
- **Managed Medi-Cal Long-Term Supports and Services (MLTSS)**: In CCI counties, Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MLTSS and Medicare wraparound benefits. MLTSS included In-Home Supportive Services (IHSS)

On May 2, 2013, the CalOptima Board of Directors authorized MOUs with the Orange County Social Services Agency (SSA) and Orange County In-Home Supportive Services Public Authority (IHSS PA). The MOUs established, among other things, provisions related to sharing confidential beneficiary information and development of care coordination and referral processes. However, when these MOUs were developed, the CCI implementation date was not known. On March 6, 2014, the CalOptima Board of Directors authorized modification of the MOUs with SSA and the IHSS PA to reflect an implementation date of no earlier than July 1, 2014. The updated MOUs expired on December 31, 2017.

Under statute, all components of CCI, including MLTSS, remained operational as long as the CCI generated net General Fund savings and was cost-effective as determined by the California Department of Finance. In January 2017, however, the administration determined that the CCI was not cost-effective and as a result, IHSS was removed from MLTSS effective January 1, 2018. Welfare and Institutions Code (WIC) section 14186, part of the original implementing CCI legislation, was amended to remove IHSS as a managed care benefit. New WIC Section 14186, subdivisions (b)(6) and (b)(9) provide that

the Legislature's intent was to allow the county and managed care plans to continue to share data as necessary "to improve care coordination, promote shared understanding of the consumer's needs, and provide appropriate coordination to IHSS and other long-term services and supports." To support this goal, the Department of Health Care Services (DHCS) is requiring plans participating in CCI to ensure that MOUs with the county IHSS administrating agency regarding information sharing and care coordination. A separate MOU with the local Public Authorities is no longer required.

Under the new statute, effective January 1, 2018, IHSS is no longer a Medi-Cal and Cal MediConnect managed care benefit; however, expectations for the plan to coordinate IHSS services with SSA continue. On December 22, 2017, DHCS released a new IHSS MOU template that is intended to assist CCI counties and managed care plans in their collaboration to complete the required MOU. CalOptima and SSA staff are working in partnership to develop the new MOU to reflect the shared needs of IHSS consumers in Orange County. Staff recommends Board of Directors' approval of the development and execution of a new CalOptima and SSA IHSS related MOU. The MOU will then be submitted to Orange County Board of Supervisors, if determined necessary by SSA.

Fiscal Impact
The recommended action to execute a new MOU with the County of Orange SSA to reflect changes to IHSS care coordination that became effective January 1, 2018 has no fiscal impact.

Rationale for Recommendation
In order to continue coordination of IHSS for CalOptima Medi-Cal and OneCare Connect beneficiaries, and to comply with DHCS requirements, DHCS is requiring CalOptima to update its MOU with SSA.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated May 2, 2013, Authorize the Chief Executive Officer to Execute Memoranda of Understanding with the County of Orange Social Services Agency and Orange County In-Home Supportive Services Public Authority in Connection with the Duals Demonstration (Cal MediConnect)
2. Board Action dated March 6, 2014, Approve the Chairman of the Board's Execution of a Three-Way Agreement with the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) for In-Home Supportive Services (IHSS), and Authorize and Direct the Chief Executive Officer (CEO) to Amend MOUs in Connection with Cal MediConnect and the Integration of Medi-Cal Long-Term Services and Supports (MLTSS) to Reflect an Implementation Date

/s/ Michael Schrader — *2/21/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2013
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. C. Authorize the Chief Executive Officer to Execute Memoranda of Understanding with the County of Orange Social Services Agency and Orange County In-Home Supportive Services Public Authority in Connection with the Duals Demonstration (Cal MediConnect)

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO) to enter into, with the assistance of legal counsel, a Memoranda of Understanding (MOU) with County of Orange (i) Social Services Agency (SSA) and (ii) In-Home Supportive Services (IHSS) Public Authority in connection with the Duals Demonstration (Cal MediConnect).

Background

In July 2012, Governor Brown signed legislation authorizing the Coordinated Care Initiative (CCI). The authority was provided in two pieces of legislation; Senate Bills 1008 and 1036. The CCI is expected to be implemented in eight counties, including Orange County, beginning in late 2013. The CCI is comprised of two major components:

- **Duals Demonstration**: A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system.
    - **Behavioral Health**: Health plans participating in the demonstration will be responsible for providing enrollees with access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medi-Cal. Plans will be financially responsible for all Medicare-covered behavioral health services. County health agencies will be financially responsible for some Medi-Cal specialty mental health and substance abuse services; these specialty mental health services will be carved out of the capitated payment to the participating health plans.
- **Managed Medi-Cal Long-Term Supports and Services (LTSS)**: In counties participating in the Duals Demonstration, all Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan in order to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.
- Plans will be required to have written agreements with the appropriate county agency to ensure enrollees have seamless access to Medi-Cal behavioral health services administered by the county.

Under the CCI, participating health plans will be financially responsible for all Medicare and Medi-Cal medical services applicable to Medicare Duals Special Needs Plan (D-SNP) currently. Additionally, participating plans will be financially responsible for IHSS, Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and long-term nursing home care (jointly long-term services and supports or LTSS). The goal of shifting financial responsibility for IHSS to the plans is to motivate the health plans to work more closely with their county counterparts to maximize lower-cost home-and community-based service options, such as IHSS, to improve member outcomes, and to prevent more expensive care in hospitals or nursing homes.

IHSS is California's main community-based Medi-Cal long-term care service, providing in-home personal care services for about 440,000 consumers statewide, of whom at least 75 percent are dually eligible for Medicare and Medi-Cal. IHSS is a county-administered program designed to enable consumer self-direction of care, i.e., IHSS consumers are able to hire, fire, and manage their workers. Approximately 20,000 consumers in Orange County receive IHSS benefits.

Discussion

IHSS is scheduled to become a managed care health plan benefit in the eight CCI counties beginning no sooner than October 1, 2013. While plans are to assume financial responsibility for IHSS on the program effective date, all county administrative functions will remain unchanged in at least the first year of the CCI demonstration. The Department of Health Care Services (DHCS) has directed plans to develop and execute MOUs with county agencies that reflect an agreement between the health plan and the county agency regarding the roles and responsibilities for the first year of the CCI demonstration. To facilitate that process, DHCS provided health plans and county agencies with template MOUs, which provides guidance on MOU requirements; local modifications are permitted. In order to participate in the CCI, CalOptima must enter into an MOU with both the Orange County SSA and the Orange County Public Authority. Further, DHCS has informed plans that executed MOUs must be in place no later than June 1, 2013 in order to move forward with the CCI.

Social Services Agency

Welfare & Institutions Code section 14186, subdivision (b)(6) states that it is the intent of the Legislature that by providing IHSS as a managed care benefit "counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining authorized hours for recipients." The Welfare & Institutions Code also states that participating health plans must administer the program in a specified manner, including entering into an MOU to allow the county to continue to perform specified functions. As required by law, the Orange County SSA will continue to perform tasks related to the administration of the IHSS program specified, including but not limited to:

- Assessing, approving, and authorizing each current and new member's initial and continuing need for services;
- Enrolling providers, conducting provider orientation, and retaining enrollment documentation;
- Conducting or delegating responsibility to conduct criminal background checks on all

potential providers of IHSS and exclude providers as required by current law;
- Providing assistance or delegating the responsibility to provide assistance to IHSS recipients in finding eligible providers through the establishment of a registry as well as provide training for recipients;
- Continuing to provide the local public authority with referral information of all IHSS providers;
- Pursuing overpayment recovery;
- Performing quality assurance activities;
- Sharing confidential data as necessary;
- Appointing an advisory committee;
- Additional functions as necessary.

Health plans must commit to:
- Sharing, receiving, and storing confidential beneficiary information as appropriate;
- Consulting with the county to establish referral and care coordination processes;
- Designating a contact position within the organization responsible for oversight and supervision of the terms of the MOU.

Public Authority
As required by law, the Orange County IHSS Public Authority will continue perform tasks related to the administration of the IHSS program specified in Welfare & Institutions Code section 12301.6, subdivisions (c) and (e). The proposed MOU gives the county public authority the ability to perform these functions under a managed care system. Additionally, this MOU will allow for the sharing of confidential recipient information to and from both parties to promote shared understanding of the consumer's needs and ensure appropriate access to IHSS. Specific tasks include:
- Conducting criminal background checks on all potential providers and excluding providers as required by current law;
- Providing assistance to IHSS recipients to find eligible providers through an established provider registry;
- Providing training for providers and recipients as required by current law;
- Until the function transfers to the California IHSS Authority (a Statewide Public Authority currently under development), acting as an employer of record and providing access to training IHSS providers and back up providers;
- Additional functions as necessary.

Health plans must commit to:
- Sharing, receiving, and storing confidential beneficiary information as appropriate;
- Designating a contact position within the organization responsible for oversight and supervision of the terms of the MOU.

Next Steps
CalOptima staff must obtain final Board approval to move forward with the Duals Demonstration and execute any related agreements. Execution of these County MOUs will be contingent upon final CalOptima legal department and CEO approval. The MOUs will then be submitted to Orange County Board of Supervisors for approval. Further, the MOUs will provide that the MOU is terminated immediately if the Board does not authorize the three-way agreement with CMS and DHCS with respect to implementation of the Duals Demonstration. The state's tentative targeted timing for release/execution of the three-way contracts is June 2013.

Fiscal Impact
The MOUs under consideration do not currently contain a funding component. There is no budget for this MOU and it will have no fiscal impact. Staffing for the Duals Demonstration/CCI is covered by funding authority approved by the Board on January 3, 2013. When approval for the final Duals Demonstration contracting arrangement is considered by the Board, a budget for that program will be included in the materials provided to the Board to assist it in its decision making process.

Rationale for Recommendation
In order for CalOptima to be eligible to participate in the Duals Demonstration, it must execute MOUs with County IHSS programs no later than June 1, 2013.

Concurrence
Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *4/26/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. F. Approve the Chairman of the Board's Execution of a Three-Way Agreement with the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) for In-Home Supportive Services (IHSS), and Authorize and Direct the Chief Executive Officer (CEO) to Amend MOUs in Connection with Cal MediConnect and the Integration of Medi-Cal Long-Term Services and Supports (MLTSS) to Reflect an Implementation Date

Contact

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

Recommended Actions

1. Approve the Chairman of the Board's execution of a three-way agreement with CDSS and DHCS for IHSS rather than the previously approved two-way agreement between CalOptima and CDSS; and
2. Authorize and direct the CEO to execute amendments, with the assistance of legal counsel, to MOUs with the County of Orange Social Services Agency (SSA) and IHSS Public Authority (PA) for IHSS to reflect an implementation date of no earlier than July 1, 2014.

Background

In July 2012, Governor Brown signed legislation authorizing the Coordinated Care Initiative (CCI). The authority was provided in two pieces of legislation: Senate Bills 1008 and 1036. In June 2013, this authority was modified by CCI Trailer Bill (SB 94). The CCI is expected to be implemented in eight counties, including Orange County, beginning in April 2014. The CCI is comprised of two major components:

- **Duals Demonstration**: A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system. The Demonstration is now referred to as Cal MediConnect.
- **Managed Medi-Cal Long-Term Supports and Services (MLTSS)**: In CCI counties, Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MLTSS and Medicare wrap-around benefits.

In preparation for the CCI, on May 2, 2013, the CalOptima Board of Directors authorized the CEO to enter into the initial MOU between SSA and IHSS PA. CalOptima is now required to modify the MOUs with SSA and the IHSS PA. Additionally, on December 5, 2013, the CalOptima Board of Directors authorized and directed the Chairman of the Board of Directors to enter an agreement with CDSS. Subsequently, CalOptima was notified that the agreement must be executed by February 24,

2014 and that the agreement would be modified to be a three-way agreement with CDSS to also include DHCS.

Discussion

CalOptima entered MOUs with SSA and the IHSS PA in 2013 regarding SSA's and IHSS PA's continuing obligations with respect to administration of the IHSS program and CalOptima's obligations with respect to integrating IHSS as a plan benefit. At the time the MOUs were developed, Cal MediConnect and MLTSS participation were linked. Cal MediConnect and MLTSS participation are no longer linked, and DHCS may choose to implement both, one or neither. Further, plans may choose not to participate in Cal MediConnect, but may still be required to participate in MLTSS.

CalOptima anticipates that MLTSS, including IHSS, will be integrated as a CalOptima Medi-Cal benefit effective no earlier than July 1, 2014. At the time the initial MOUs were developed, the effective date of MLTSS integration was not known. DHCS is now requiring CalOptima to modify its existing IHSS related MOUs to reflect the implementation date. Board of Director's approval is requested to modify the IHSS related MOUs. The MOUs will then be submitted to the Orange County Board of Supervisors for approval, if required by SSA and/or the IHSS PA.

In addition to the requirement to enter into MOUs with SSA and the IHSS PA, CalOptima had been informed that it would also be required to enter into an agreement with CDSS for IHSS. The Board of Directors authorized execution of such agreement on December 5, 2013. Subsequently, guidance was provided modifying the agreement as a three-way agreement to also include DHCS. In order to meet the February 24, 2014 regulatory deadline, CalOptima's Chairman of the Board executed the agreement on February 14, 2014. Board of Director's ratification is requested for the execution of the three-way agreement with CDSS and DHCS.

Fiscal Impact

These MOUs, as modified, do not contain a funding component. There is no budget for this MOU and it will have no fiscal impact.

Rationale for Recommendation

In order for CalOptima to participate in Cal MediConnect and integrate MLTSS benefits into Medi-Cal, execution of a three-way agreement with DHCS and CDSS was required by February 24, 2014. Also, DHCS is requiring CalOptima to amend its MOUs related to these services to reflect an implementation of no earlier than July 1, 2014.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

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

2/28/2014 — **Date**

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
27. Consider Authorizing a Contract with eVisit Services Vendor

Contacts
Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Donald Sharps, M.D., Medical Director, (714) 246-8737
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions
1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with virtual visit (eVisit) services vendor, Teladoc Health, Inc. to provide virtual urgent care visits, including after-hour access for one year:
    a. For CalOptima Community Network (CCN)/CalOptima Direct (COD) Medi-Cal members for acute nonemergency medical conditions; and
    b. For all CalOptima Medi-Cal members (except Kaiser) for behavioral health conditions.
2. Allocate up to $950,000 of Intergovernmental Transfer (IGT) 9 dollars to fund this engagement.

Background
On February 4, 2021, to continue responding to the impact of COVID-19 on CalOptima members and address access issues, staff presented implementation costs associated with the eVisit and eConsult projects. The CalOptima Board of Directors approved the recommended allocation of IGT 9 funds in the amount of $2.0 million for both eVisit and eConsult initiatives (see Attachment 2).

The primary goal of eVisit services is to provide virtual access to acute nonemergency medical care and behavioral health care to the following members:

Acute nonemergency medical care:
- CCN/COD Medi-Cal members

Behavioral health care:
- All CalOptima Medi-Cal members (except for those assigned to Kaiser) as CalOptima is responsible for integrating members' behavioral health services with medical care

Interactions via eVisit are between a member and provider. CalOptima management believes that eVisits can assist with access and availability during the COVID-19 pandemic and beyond, when provider offices may have limited capabilities, and members might not be aware of their virtual care capacity. In addition, the eVisit services will be tied to CalOptima's Nurse Advice Line (1-844-447-8441) and Behavioral Health After-Hours Line (1-855-877-3885).

After completing both Request for Information (RFI) and Request for Proposal (RFP) processes, staff recommend contracting with Teladoc, an eVisit solution vendor that helps health plans provide member access to comprehensive virtual care that may otherwise be difficult for them to obtain.

Discussion
CalOptima's RFP minimum requirements for the eVisit services vendor include the following:

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- The eVisit vendor must provide an interactive audio, video or data telecommunications system that permits real-time or same-day communication between the health care provider at the distant site and the member at the originating site, such as at home.
- The service must be accessible on any device with a camera and microphone (e.g., smartphone, tablet, computer or laptop).
- CalOptima members should be able to self-refer to access the eVisit vendor.
- CalOptima members should also be able to access the eVisit vendor via CalOptima's Nurse Advice Line or Behavioral Health After-Hours Line.
- Through the eVisit vendor, CalOptima members should be able to access physician consultation services for acute nonemergency medical conditions and behavioral health conditions.
- The eVisit vendor must connect CalOptima members to physicians under contract with providers who are licensed to practice medicine in California.
- The eVisit vendor should have a contracted interpreter service to provide eVisit services in various languages. The contracted interpreter vendor must provide interpreter services when requested and inform members that interpreter services are free.
- The eVisit vendor should provide regular data reports to CalOptima.

During the RFP process, CalOptima staff received a total of two (2) proposals. Based on the weighted scores and evaluation team discussion, CalOptima's eVisit RFP workgroup recommends that the Board authorize a contract with Teladoc. The proposal overall weighted scores are listed below:

Vendor	Weighted Score
Teladoc Health, Inc. (Teladoc)	3.69
SteadyMD	3.36

Teladoc is believed to be the largest provider of member eVisit services in the United States and offers a comprehensive, integrated virtual care solution capable of serving organizations and members anywhere via virtual visits by phone, web or mobile app.

CalOptima's eVisit RFP workgroup recommends that the Board authorization expenditures in an amount not to exceed $950,000 of IGT 9 funds for Year 1 implementation of the eVisit program. The estimated annual cost is based on CalOptima membership, and staff projections that start-up/implementation costs in Year 1 would not exceed $100,000 (which is part of the requested $950,000). The eVisit Vendor will be offered CalOptima's Professional Services Contract for Specialists. Pricing will be per visit based on Medi-Cal fee schedule rates, including an amendment for a per member per month (PMPM) negotiated rate. Staff note that PMPM payments will include member engagement activities and administrative fees. The internal financial analysis and research showed evidence that PMPM fee follows the industry standards and market rates. Staff recommend that the Board authorize a contract with Teladoc for this initiative.

This project will target the Medi-Cal CCN/COD member population for acute nonemergency medical care and all CalOptima Medi-Cal (except Kaiser) members for behavioral health conditions. Staff will evaluate the effectiveness of the program in helping members meet their medical and/or behavioral needs. Upon completion of the evaluation, staff will return to the Board with recommendations on whether to continue this program beyond its first year, and also whether to consider expanding it to other populations (e.g., OneCare Connect).

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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 Department of Health Care Services in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or quality initiatives, the expenditures are charged to CalOptima's General and Administrative categories, which are included in the administrative loss ratio (ALR).

Fiscal Impact

The recommended action to authorize the contract with eVisit services vendor, Teladoc and approve the allocation of IGT 9 funds in an amount not to exceed $950,000 for year one of implementation has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Upon evaluation, if results are favorable, Management will return to the Board to request additional IGT funding to continue eVisit services or will include the expenses in future operating budgets.

Rationale for Recommendation

The recommended actions would allow CalOptima to provide additional access to quality care for members during and after the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated February 4, 2021, Consider Reallocation of Intergovernmental Transfer (IGT) 9 Funds Allocated for Virtual Urgent Care (eVisit) to Support both eVisit and eConsult Implementation During Coronavirus (COVID-19) Pandemic and Beyond

/s Richard Sanchez — *02/024/2021*

Authorized Signature — **Date**

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Continued to a Future Meeting

Attachment to the March 4, 2021 Board of Directors Meeting – Agenda Item 27

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Teladoc Health, Inc.	2 Manhattanville Rd.	Purchase	NY	10577

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Reallocation of Intergovernmental Transfer (IGT) 9 Funds Allocated for Virtual Urgent Care (eVisit) to Support both eVisit and eConsult Implementation During Coronavirus (COVID-19) Pandemic and Beyond

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574

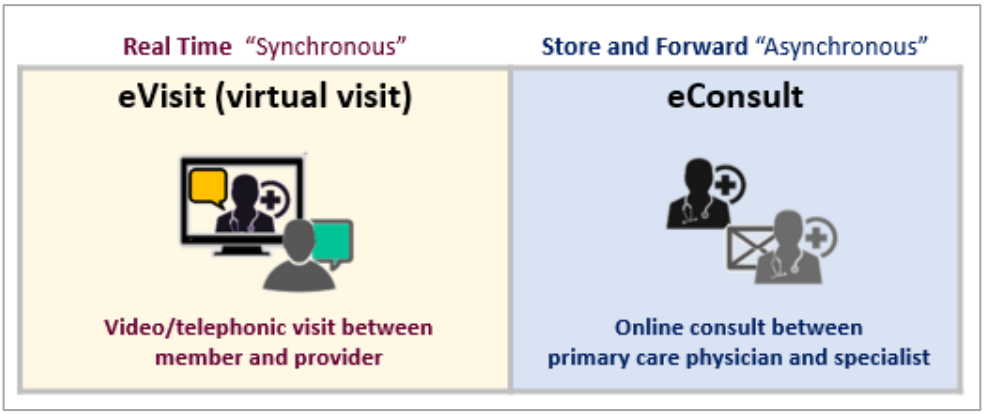
Recommended Action

Reallocate $2 million in Intergovernmental Transfer (IGT) 9 funds previously allocated for the virtual urgent care (eVisit) project to support both the eVisit and eConsult projects for CalOptima Direct, including CalOptima Community Network (COD/CCN) members and providers, during and after the COVID-19 pandemic.

Background

At its October 1, 2020 meeting, the CalOptima Board of Directors approved the redirection of up to $2.0 million in IGT 9 funds from the Member Access and Engagement: Expanded Office Hours Pilot to contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CCN members during and after the COVID-19 pandemic. Based on this Board action, staff released a Request for Proposal (RFP) with the intent of selecting an eVisit services provider that meets COD/CCN members' medical needs and CalOptima's business requirements during the COVID-19 pandemic. The expectation is that the eVisit services vendor will offer virtual visits, including after-hour access for acute, non-emergency medical conditions and behavioral health conditions through the vendor's own provider network. eVisit interactions are between member and provider. Staff is continuing to work on this RFP process and will return to the Board in the near future to request approval to contract with a eVisit vendor (as well as for an eConsult vendor, as discussed below).

In addition to the eVisit project, another integral part of CalOptima's Virtual Care Strategy is the eConsult project, for which operating funding has not yet been fully allocated. An eConsult is an asynchronous service whereby a member's treating health care practitioner, such as a primary care provider (PCP), requests the opinion and/or treatment advice of another health care practitioner with specialty expertise to assist in the diagnosis and/or management of the member's health care needs, without having face-to-face contact with the specialist. Unlike synchronous (real-time) consultations, asynchronous service models are commonly referred to as "store and forward," where a patient's clinical information is collected and sent electronically to another site for evaluation. eConsult is an online interaction between provider and provider. The following diagram highlights the distinction between real-time (synchronous) eVisits, that are generally between a member and that member's provider, and non-real-time (asynchronous) eConsult services, which are typically between the member's primary care provider and a specialist):



With eVisits, members have the option, when appropriate, of receiving care without going into the PCPs' offices. With eConsults, PCPs are better able to determine the best course of treatment for members with guidance from specialists and may avoid the member needing to be referred to a specialist. Moreover, should a member need to see a specialist in person, the specialist will be prepared with an enhanced referral based on eConsult information, which should help to ensure that the visit effectively meets the member's needs. Overall, eConsults support higher-value in-person visits, streamlined communication between PCPs and specialists, shorter wait times for members, and prioritization of members in need of more timely or intensive specialist services.

While conducting Request for Information (RFI) and RFP processes for the eVisit and eConsult projects, staff determined that the cost to implement the eConsult project will be significantly more than the $350,000 included for Telehealth in the CalOptima Fiscal Year 2019-20 Capital Budget. To date, there is approximately $250,000 remaining for this capital project. Fortunately, the implementation cost for the eVisit project is projected to be less costly. Therefore, staff anticipate that the $2 million in IGT 9 funds allocated at the October 1, 2020 Board meeting for a 24/7 virtual urgent care vendor for services will be sufficient to support both the eVisit and the eConsult projects. Please see the outline below of how RFI and RFP processes are being conducted for these projects:

eVisit:

- Staff completed the RFI process during Q4 of 2020 and received three (3) bidder responses.
- RFI responses were used to finalize scope of work. Through RFI, staff learned that implementation fees for eVisit would be approximately $200,000.
- Staff released the RFP in December 2020; staff expect to receive proposals by the end of January 2021.

eConsult:

- Staff released the RFP during Q3 of 2020 and received four (4) proposals
- After internal workgroup evaluations, staff narrowed down to two vendors; however, through RFP, staff also learned that implementation fees for eConsult are significantly more expensive than anticipated due to these bidders' requiring of annual licensing fees (licensing fees cost approximately $600,000). The initial eConsult budget was established for Fiscal Year 2019-20. The budget amount included $350,000 of capital budget only for implementation. Operating

expenses were to be budgeted after year 1. The budget estimate was originally developed in 2019 before receiving the information available today. Since then project scope has greatly increased due to COVID-19 and current circumstances, thus resulting increased costs.

- To gain a better understanding of the provider experience with eConsult and assist in implementing this initiative, provider survey was sent out November 2020; staff received 30 provider responses.
- Staff performed data analysis and refined project scope in order for these bidders to submit new pricing proposals.
- Since the current budget does not cover project implementation costs, staff aims to repurpose some of the eVisit's IGT 9 funds to support this initiative.

Discussion

As the COVID-19 pandemic continues to threaten the lives of many CalOptima members, staff anticipates that both the eVisit and eConsult services will provide alternate and/or additional access to care for COD/CCN members during this challenging time.

Currently, staff estimate implementation costs for the eVisit project to be less than $200,000, based on the RFI responses. This leaves $1.8 million in IGT 9 funds available for other purposes. Therefore, staff propose expanding the approved use of the $2 million in IGT 9 funds to support the eConsult project as well, consistent with CalOptima's overarching Virtual Care Strategy. With this authorization to expand the use of the funds, CalOptima staff would refine the project scope so bidders can submit new pricing proposals. This would also allow the eConsult project to be implemented more quickly. Staff note that RFI was not conducted for the eConsult project due to the tight project implementation timeframe. However, after learning that today's market is different than what staff had anticipated, as lessons learned, the internal workgroup decided to conduct both RFI and RFP for the eVisit project to better align with project scope and budget planning. Staff will return to the Board to seek approval to contract with the recommended eVisit and eConsult vendors identified through the RFP processes.

Staff also note that with the IGT 9 funding, CalOptima aims to initiate these two projects and pay for the first year's implementation and training fees. Staff plan to launch these projects as pilots with CCN populations, and will evaluate the effectiveness of these programs in helping members meet their medical and/or behavioral needs. Upon completion of the evaluation, staff will return to the Board to request authorization to continue these programs and request appropriate funding.

In addition, providers using eConsult services will be required to submit an electronic claim for services rendered. The eConsult engagement will be a required step for providers to complete as part of the authorization request process. The future goal would be that through the eConsult services, members can avoid unneeded specialist visits, thus improving access and availability to specialist providers.

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 Department of Health Care Services (DHCS). To the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the dollars would be charged to CalOptima's administrative loss ratio (ALR) rather than medical loss ratio (MLR). The recommendation to allow Board-allocated

IGT 9 funds to support both eVisit and eConsult implementation is consistent with the purpose of the IGT 9 funds to cover medically necessary Medi-Cal services or qualifying quality initiatives.

Fiscal Impact

The recommended action to approve reallocation of $2 million in IGT 9 funds previously allocated for the eVisit project to support both eVisit and eConsult projects for COD/CCN members and providers has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action is consistent with the original aim for IGT 9 to improve Member Access and Engagement and will enable CalOptima to provide increased access to quality care for COD/CCN members during and after the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action dated May 7, 2020, 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
3. Board Action dated October 1, 2020, Consider Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

/s/ Richard Sanchez — *01/27/2021*

Authorized Signature — **Date**

Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 22

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
RubiconMD, Inc.	214 Forest Avenue	New Rochelle	NY	10804
Safety Net Connect Inc.	4600 Campus Drive, Suite 101	Newport Beach	CA	92660
Teladoc Health, Inc.	2 Manhattanville Rd.	Purchase	NY	10577
SteadyMD Headquarters SteadyMD Los Angeles	4625 Lindell Blvd, Suite 224 2629 Townsgate Rd, Suite 130	St. Louis Westlake Village	MO CA	63108 91361
CirrusMD	3513 Brighton Blvd., Suite 230	Denver	CO	80216

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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

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

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.

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**

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.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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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

I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. Data Architect

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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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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(949) 229-7684 FAX

EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL COM
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CalOptima
A Public Agency
Better. Together.

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

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.

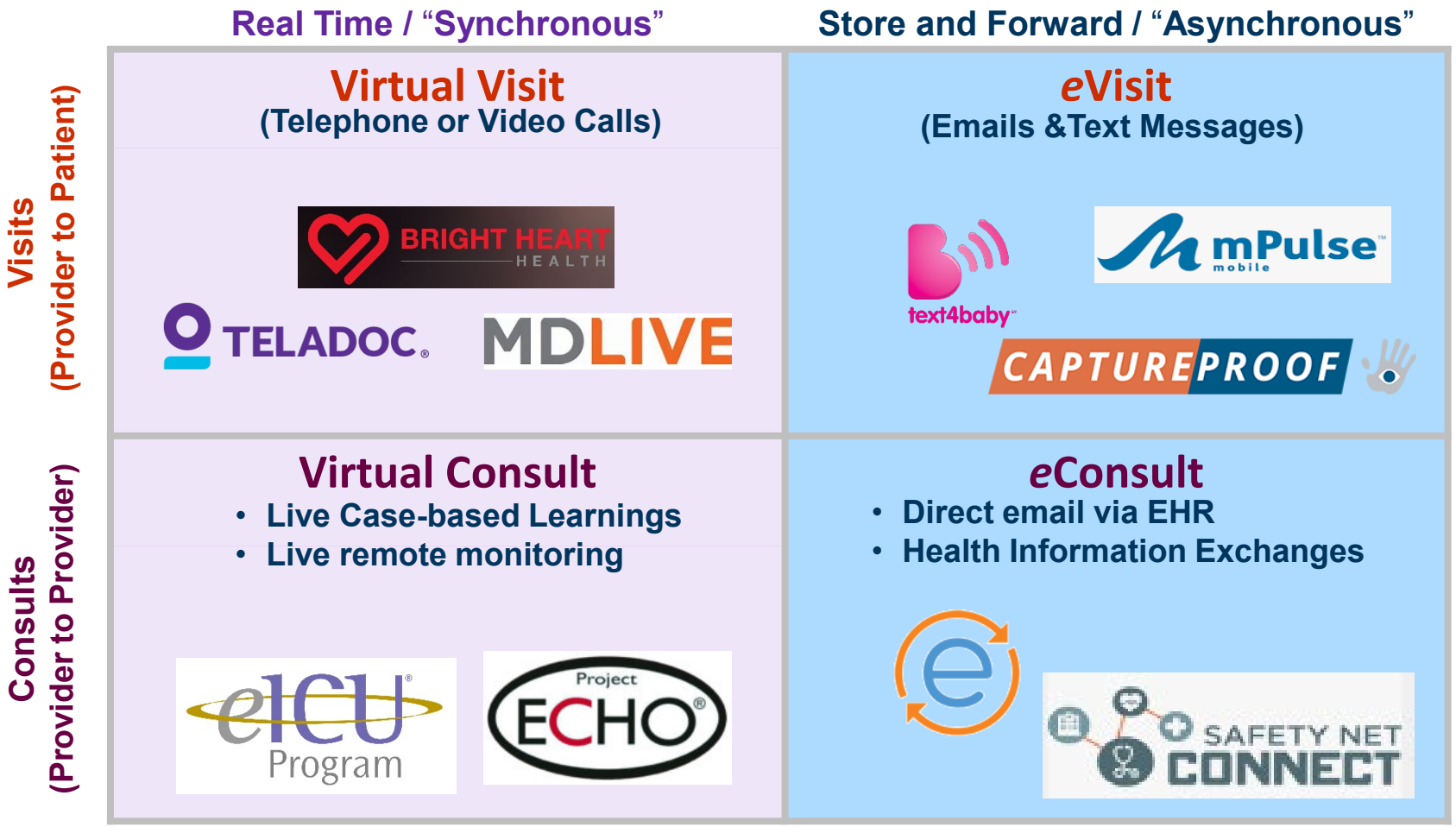
Virtual Care Modalities

	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.

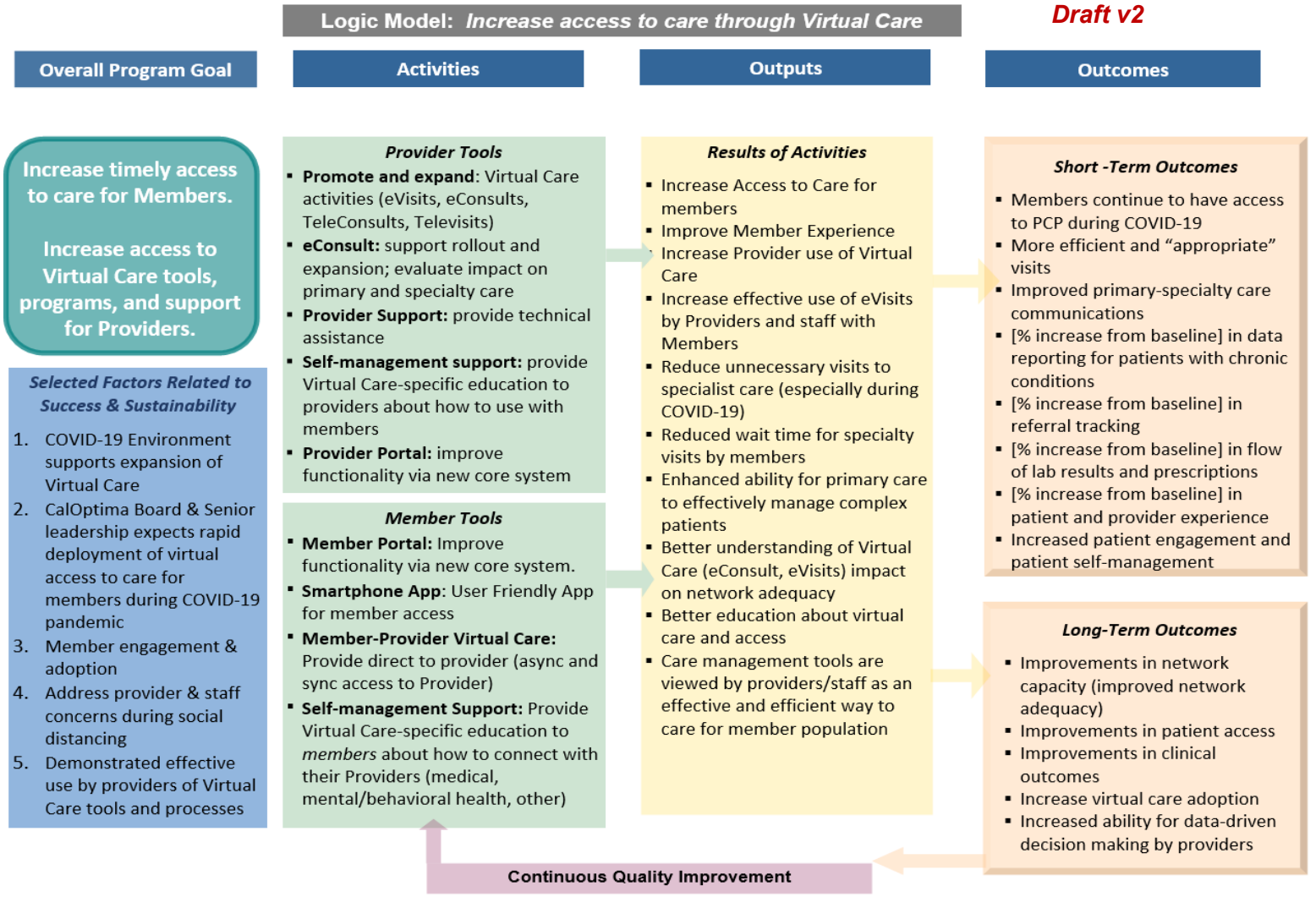
Examples of Virtual Care Modalities



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.

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

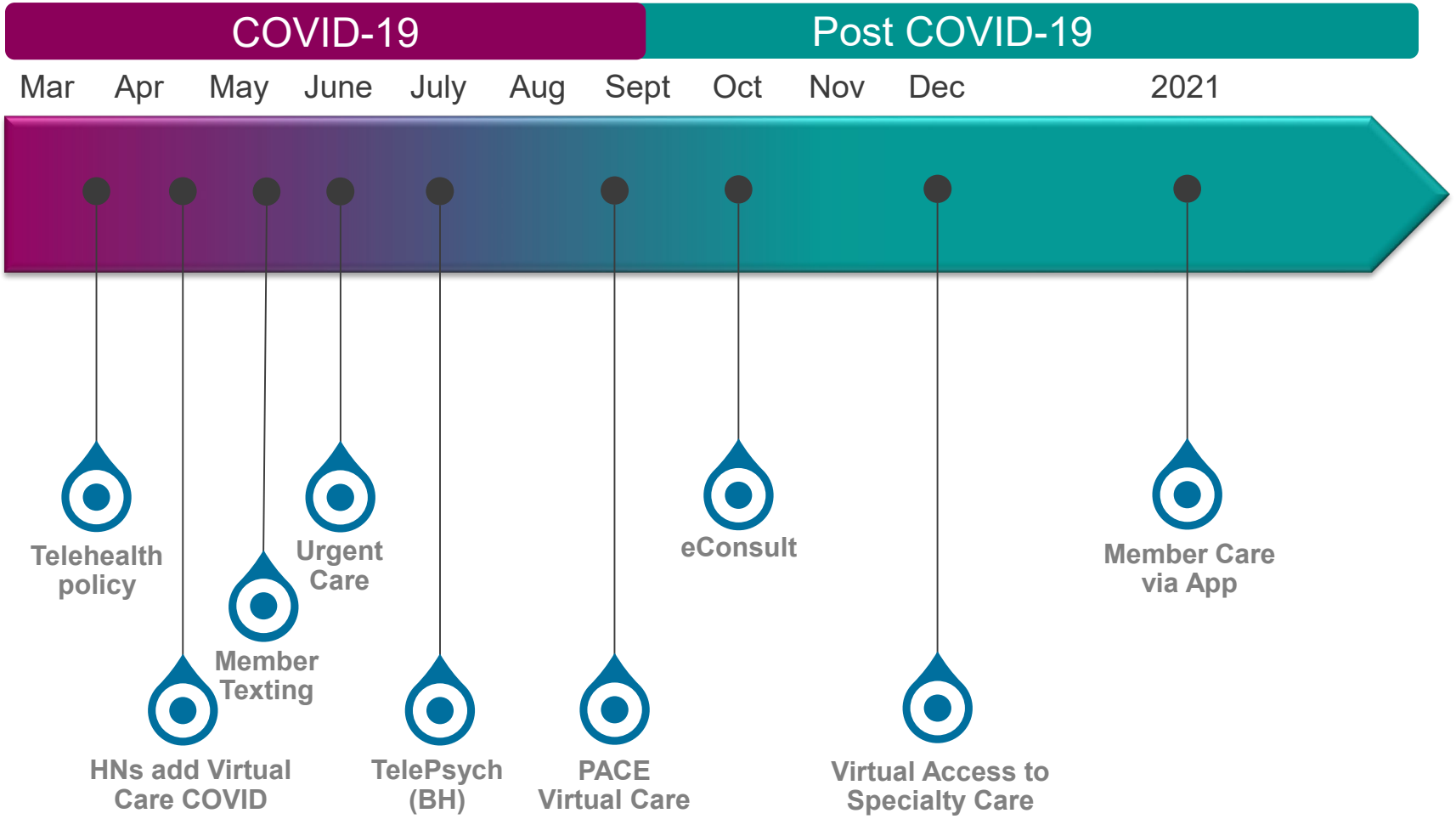
Regulations: Will They Stay, or Will They Go?

- 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



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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

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)**

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**

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

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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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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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

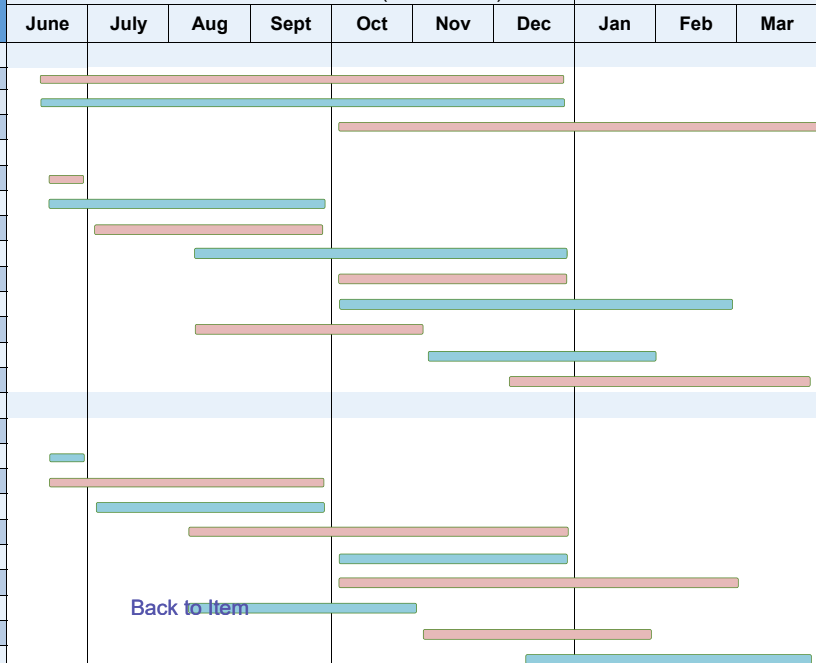
Long-Term Outcomes

- 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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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

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.

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.

Back to Agenda Back to Item

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

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**

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,

effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

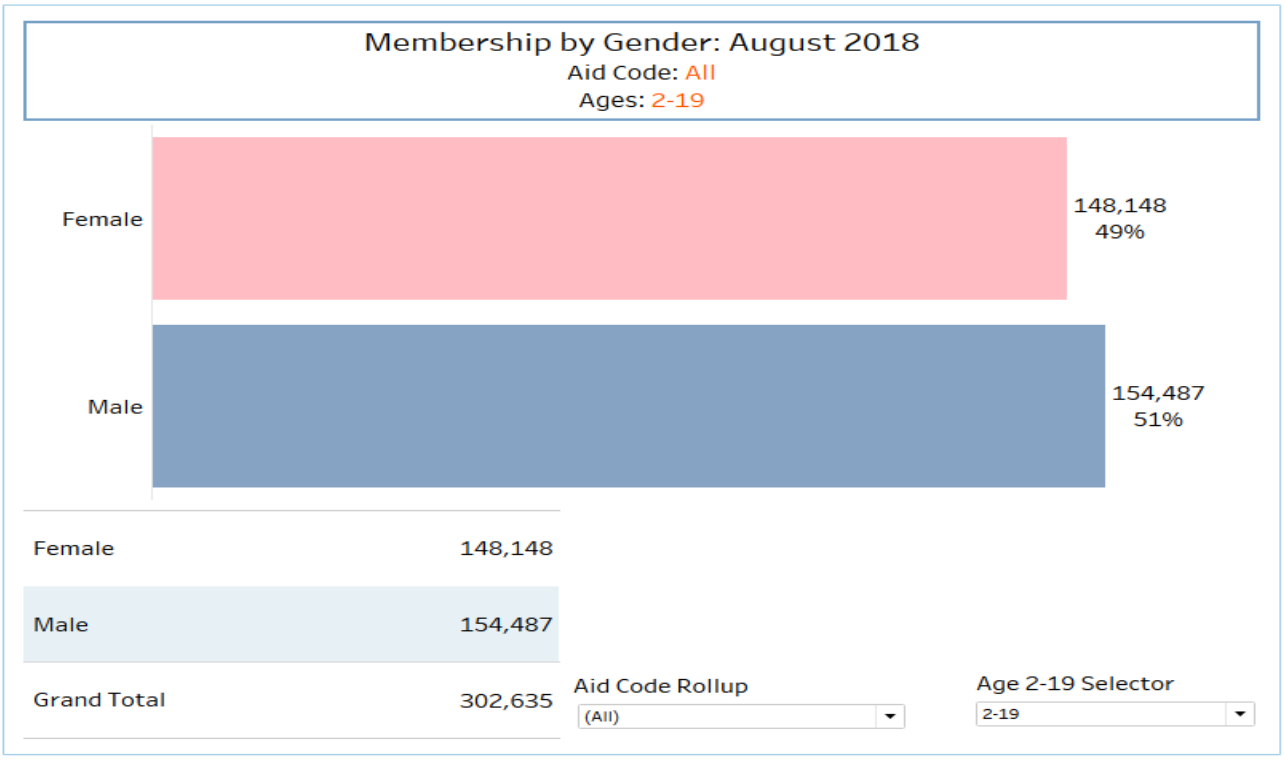
- **CalOptima's Target Population**
  - **Population Identification [PHM2]**
    - CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is the Member Health Needs Assessment 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.

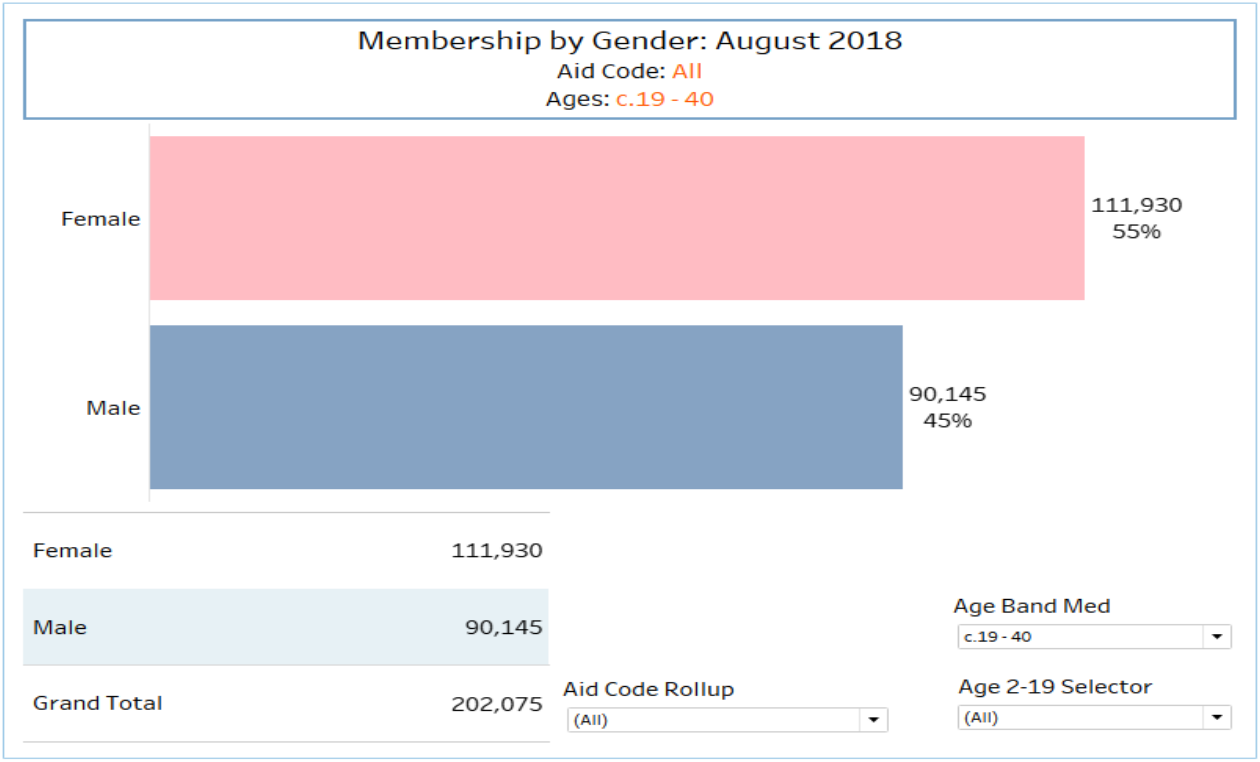
    Example of Member Segmentation – *Source: Tableau_f_dx_v33_m95_08.24.18*

  - *By Age and Gender*

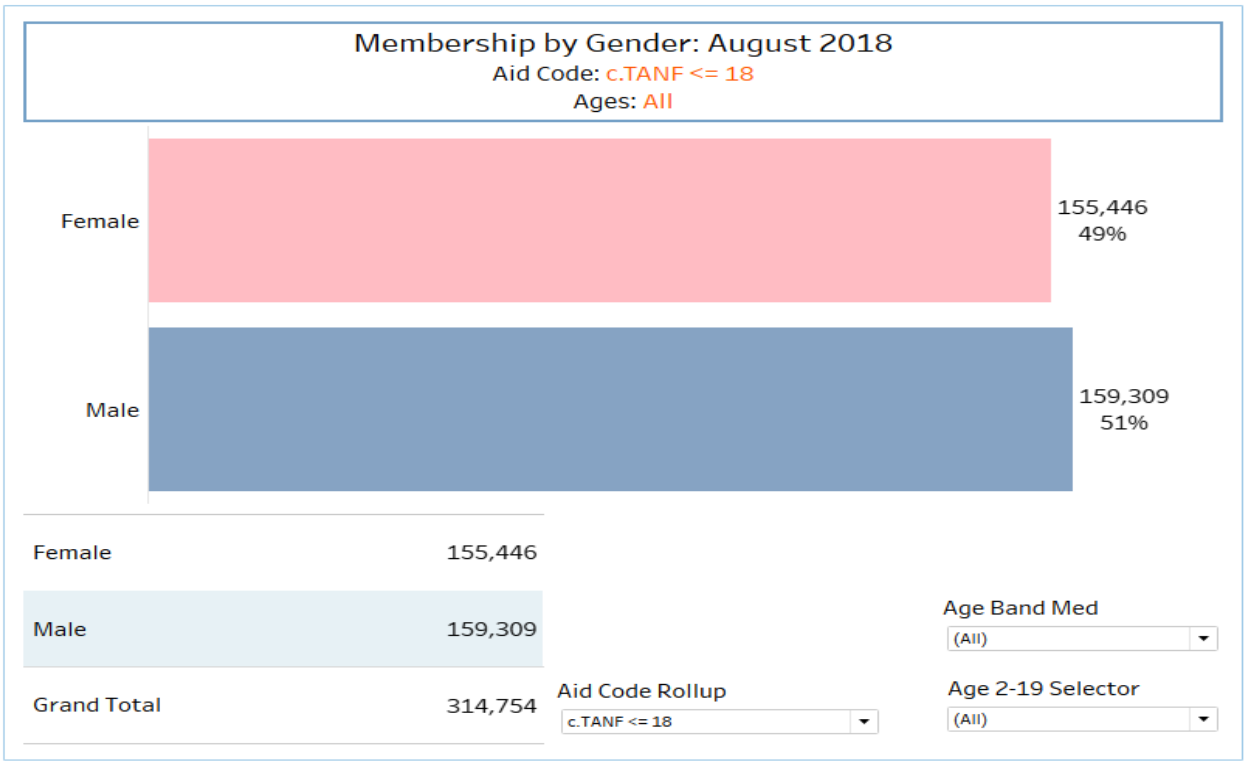
    - *Ages 2–19*



- *Adults 19–40*

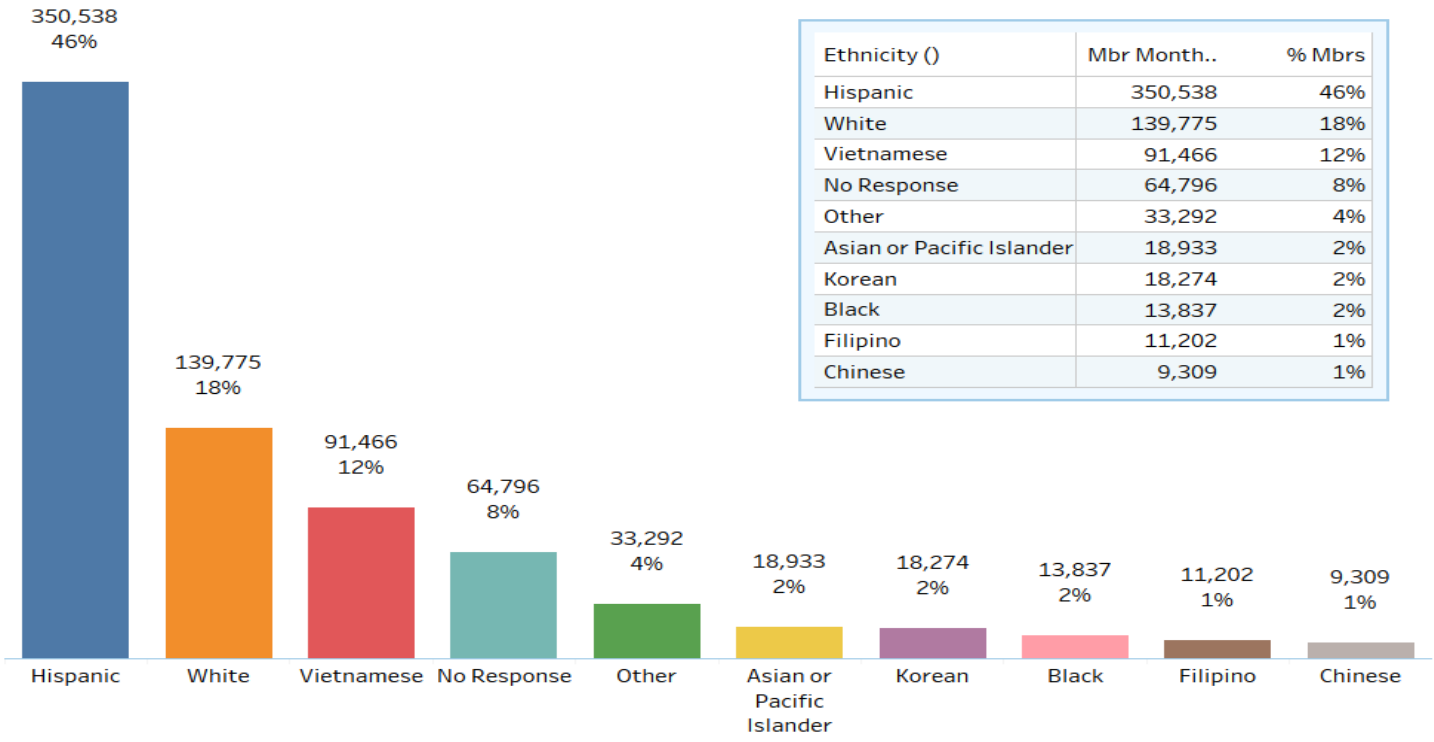


- *TANF (<18 Non-SPD)*



- *Ethnicity*

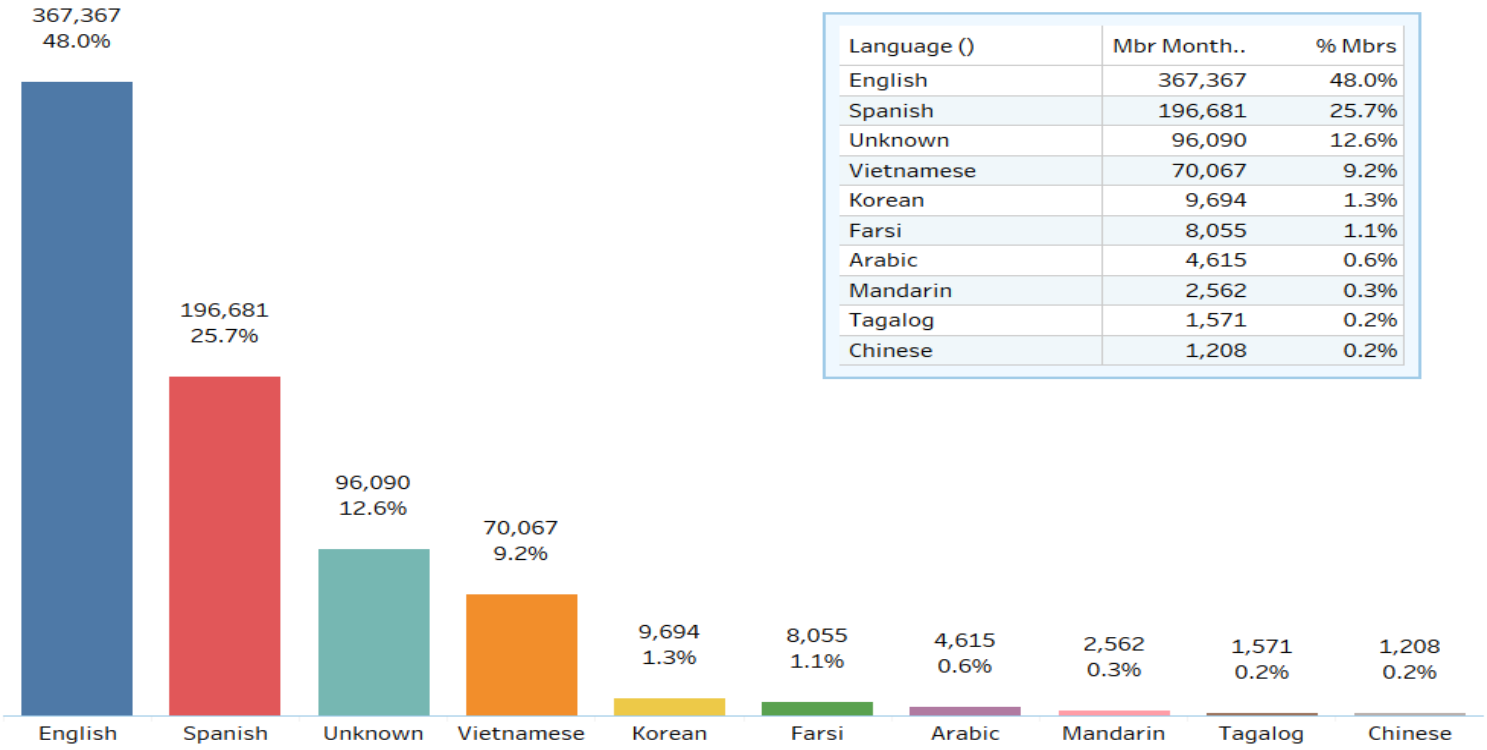
CalOptima Top Ten Member Ethnicities
Aid Code: All
Ages: All
Total Members: 764,774



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%

- *Language*

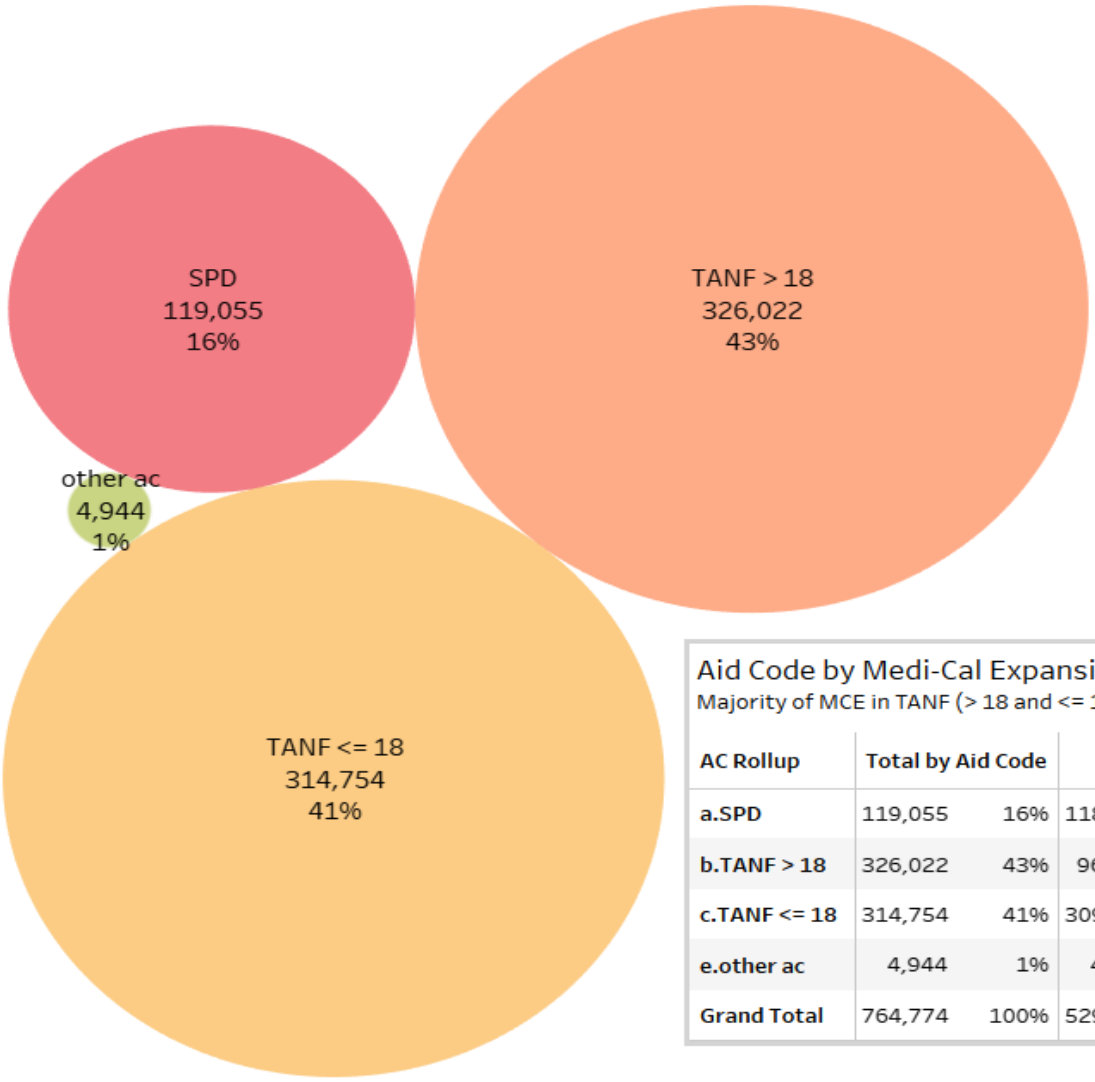
CalOptima Top Ten Member Languages
Aid Code: All
Ages: All
Total Members: 764,774



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

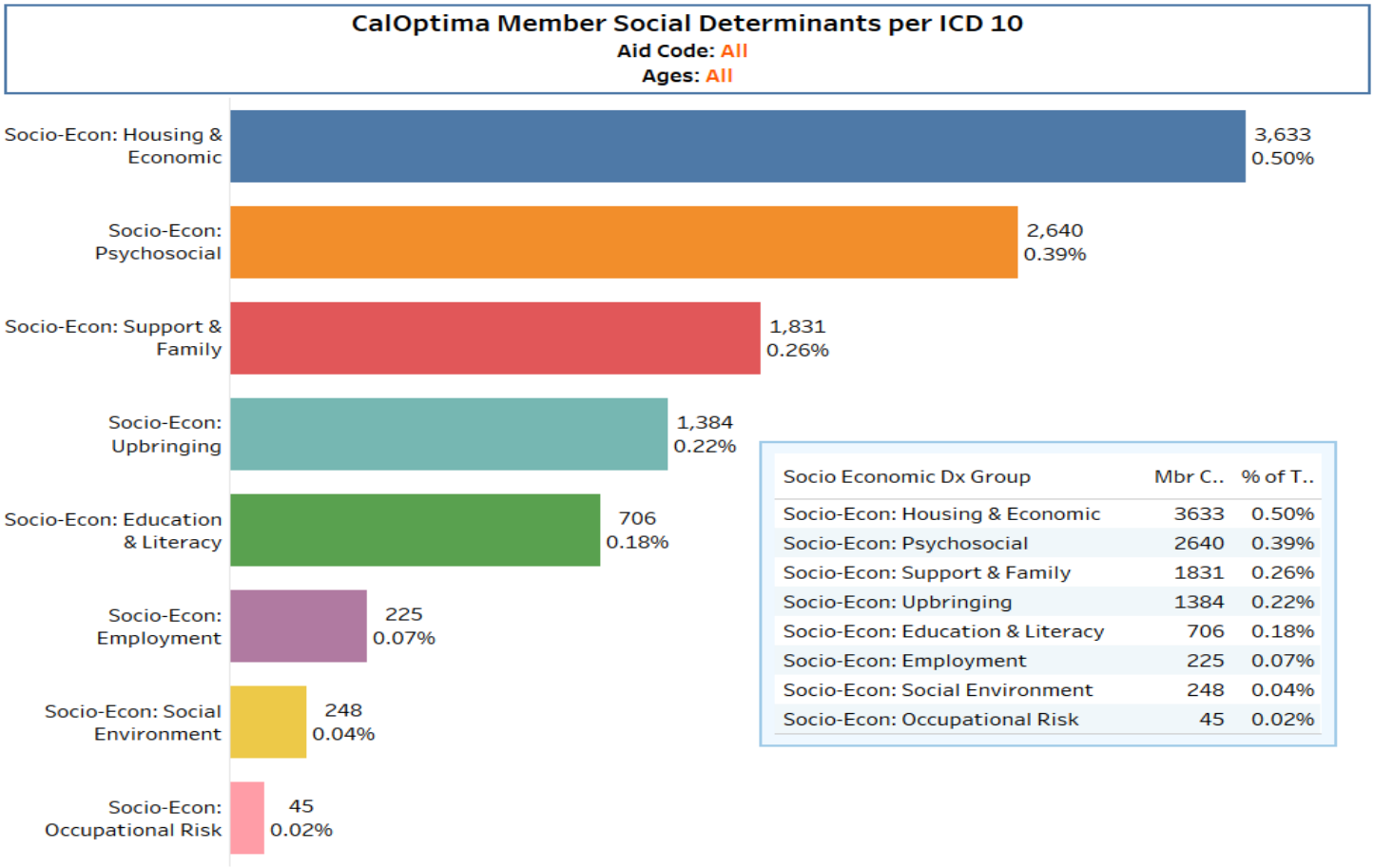


Aid Code by Medi-Cal Expansion (MCE)

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

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

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

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

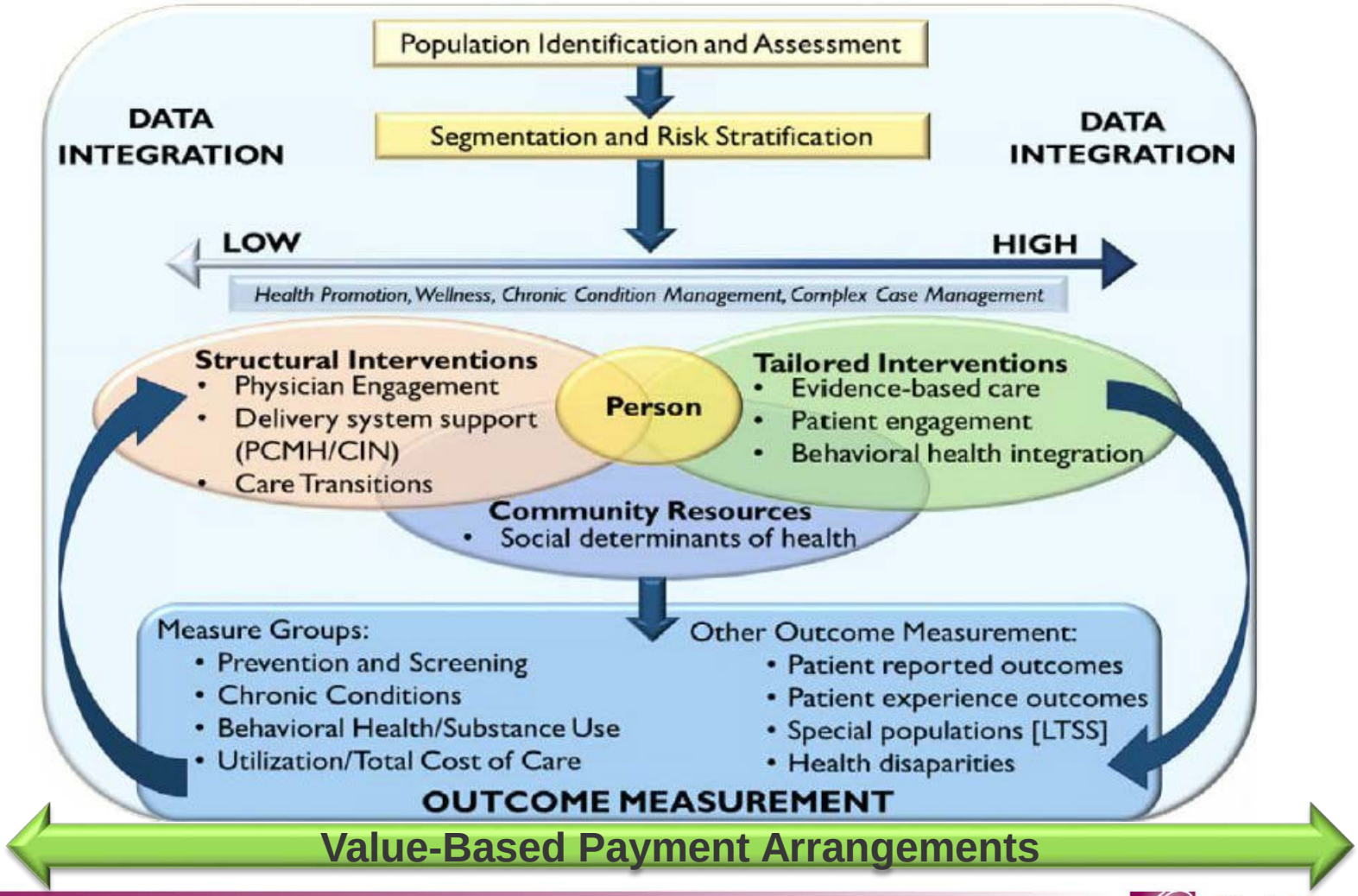
- Quality Improvement (QI) 5 Complex Case Management (CCM)
- QI 6 Disease Management (DM)
- Measuring Effectiveness by Individual Program

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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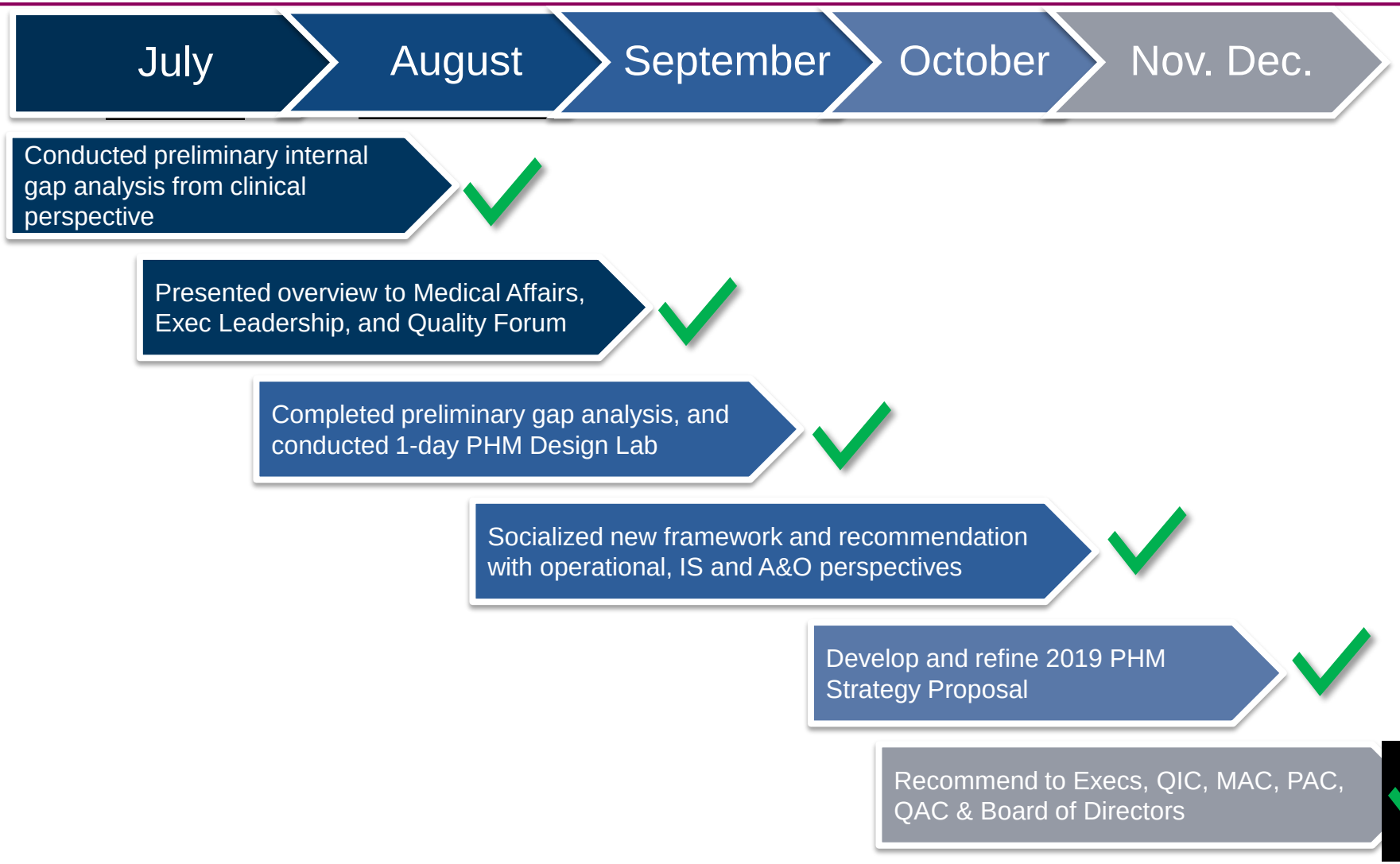
2018 Accomplishments



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.

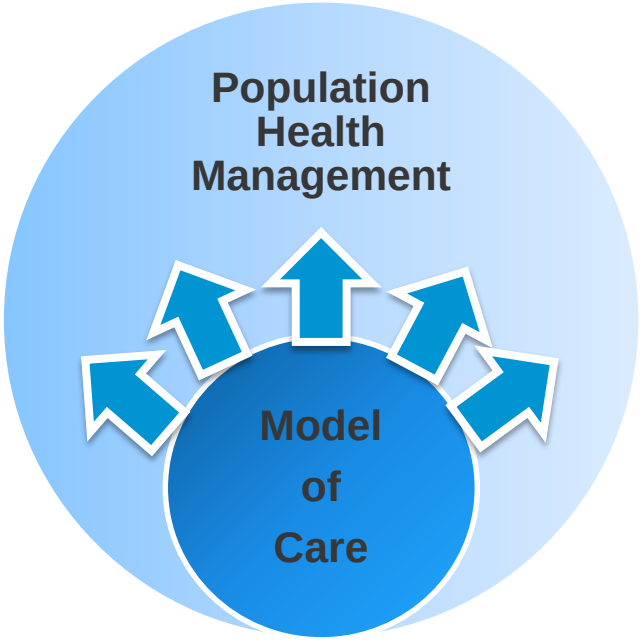
Data source: Documented Process and Materials

PHM1 Four Areas of Focus

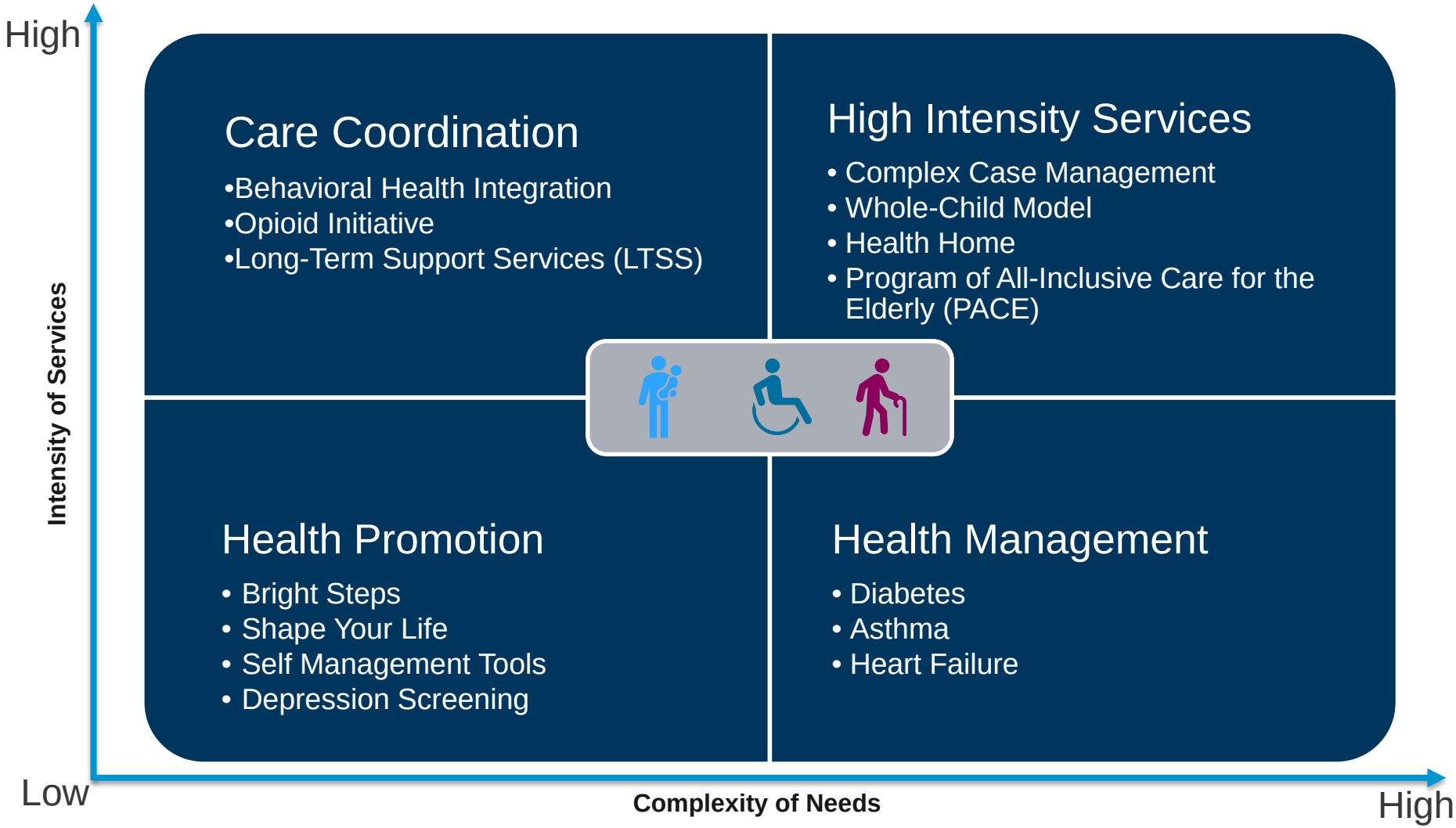
Improving Outcomes Across All Settings

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.



Current CalOptima Programs



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

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 October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8400

Recommended Action

Recommend approving the redirection of up to $2.0 million of IGT 9 funds originally allocated for the Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) Pilot towards contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CalOptima Community Network (CCN) members during and after the COVID-19 pandemic

Background

On April 2, 2020, the Board of Directors (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 (refer to Attachment 1). Among these focus areas, the Board approved allocating $2.0 million for Expanded Office Hours to improve member access and engagement.

On May 7, 2020, CalOptima staff presented the Virtual Care Strategy and Roadmap (refer to Attachment 2) to provide additional access to quality care for our members and providers during and after the pandemic. One of the strategies introduced to the Board was to contract with a vendor offering virtual urgent care visits, including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions. However, this strategy was postponed due to lack of available funding and deferred until CalOptima staff is able to identify appropriate funding.

As the COVID-19 pandemic continues to spread and disrupt the lives of many CalOptima members, CalOptima staff re-evaluated the structure of the Expanded Office Hours program and concluded that CalOptima is faced with new access challenges due to the COVID-19 pandemic that should be addressed. The Expanded Office Hours program was originally designed to provide additional office hours access to members in highly demanded and impacted areas. However, with the ongoing pandemic, members are less willing to come into the office for routine and preventive care services due to fear of COVID-19 and many provider offices are experiencing decreased office visits, and hence are less willing to expand their available office hours.

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Discussion

The Expanded Office Hours pilot was proposed as a two-year program to incentivize primary care providers and/or clinics to expand after-hour primary care services for CalOptima members in highly demanded and highly impacted areas. Unfortunately, this program was developed before the COVID-19 pandemic, and CalOptima staff now recommends shifting our efforts to support the urgent needs of our members through the use of virtual care.

CalOptima staff proposes redirecting the $2 million IGT-9 funds originally allocated for the Expanded Office Hours pilot to release a Request for Proposal (RFP) and selecting a vendor that meets our CCN members' medical needs and CalOptima's business requirements during the COVID-19 pandemic. Staff recommends starting this program with CCN members first and will consider extending it to other networks in the future. Staff will return to the Board to seek authority for approval to contract with the recommended vendor selected through the RFP process for services that will include a virtual care platform and virtual provider network, along with virtual care expertise to ensure a successful implementation of the 24/7 virtual urgent care initiative, including member and provider engagement and adoption.

With this proposed virtual care strategy, CalOptima staff believe that virtual urgent care after hours can improve member access to needed care on demand, decrease wait times, and reduce avoidable emergency department visits.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for as part of the Medi-Cal capitation revenue CalOptima receives from the Department of Health Care Services (DHCS) in exchange for making covered, medically-necessary care available to assigned Medi-Cal beneficiaries. Any expenditures of IGT-9 funds not meeting these requirements are categorized by the DHCS as part of CalOptima's administrative expenses. The recommendation to redirect Board-allocated IGT 9 funds to virtual urgent care services is consistent with the purpose of the IGT 9 funds to cover medically necessary Medi-Cal services or qualifying quality initiatives.

Fiscal Impact

The recommended action to redirect $2.0 million in IGT 9 funds from the Expanded Office Hours Pilot to support 24/7 virtual urgent care services for CCN members during the pandemic has no net impact to CalOptima's fiscal position. IGT 9 revenue from DHCS in Fiscal Year 2019-20 was sufficient to cover the allocated expenditures and initiatives. This expenditure of IGT funds is for a restricted, one-time purpose for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action is consistent with the original aim for IGT 9 to improve Member Access and Engagement and will enable CalOptima to provide increased access to quality care for CCN members during and after the pandemic.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
2. Board Action dated May 7, 2020, 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

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

Deleted per Ad Hoc Committee on 3/2/2021

Supplemental Item S-1

CalOptima Board Action Agenda Referral

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

Consider authorizing the preparation and release, subject to the Legal Ad Hoc's ("Ad Hoc") review of Requests for Information ("RFI") for an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers.

Contact

Legal Ad Hoc Committee Members
Chair Andrew Do
Director Mary Giammona
Director Scott Schoeffel

Recommended Action(s)

Authorize the preparation and release, subject to the Ad Hoc's review, of an RFI for an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers.

Background

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly ("PACE") program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal government. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California. Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

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Deleted per Ad Hoc Committee on 3/2/2021

Discussion

The CalOptima Board of Directors ("Board") is undergoing a strategic planning endeavor. As part of this process the Ad Hoc, established on December 3, 2020 comprised of Chair Do, Director Giammona, and Director Schoeffel, has considered how best to organize and marshal the agency's legal resources to meet the substantial and increasing demand for legal services in conjunction with upcoming changes to Medi-Cal, addressing COVID-19, and the increasing demand for access to CalOptima services.

To that end, the Ad Hoc recommends that, through an RFI process, the Board explore the retention of an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers. Following the release of the RFI, the Ad Hoc will review applications and return to the Board with a future recommendation.

Upon Board approval, the attached scope of work will be included in the RFI and serve as the information that will be requested from each law firm who may be interested in applying for such a general counsel role as to its qualifications regarding the anticipated scope of work.

Fiscal Impact

The recommended action to authorize the preparation and release of an RFI, subject to the Ad Hoc's review, has no fiscal impact to CalOptima.

Rationale for Recommendation

As part of the Board's strategic planning efforts, exploring the retention of an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers will address the substantial and increasing demand for legal services.

Attachments

General Counsel Proposed Scope of Work

Authorized Signature **Date**

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Deleted per Ad Hoc Committee on 3/2/2021

Supplemental S-1. Attachment

Request for Information
CalOptima Outside General Counsel

Scope of Work

I. Introduction

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly (PACE) program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal government. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California ("Public Laws"). Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

As part of its strategic planning efforts, the CalOptima Board of Directors ("Board") is considering how best to organize and marshal its legal resources to meet this substantial and increasing demand for legal services. To that end, the Board is exploring the retention of an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers. The Board will be requesting information from each law firm who may be interested in applying for such a general counsel role as to its qualifications regarding the anticipated scope of work set forth below.

II. General Requirements.

A. The GC must have substantial experience in representing California managed care organizations ("MCO") that serve predominantly Medi-Cal populations. It must also be

able to demonstrate experience representing MCOs serving dual-eligible and PACE program populations.

B. The GC must have an experienced senior lawyer who will serve as the principal and consistent point of contact with CalOptima personnel ("Principal Lawyer"). While it is anticipated that other GC lawyers may work on CalOptima matters from time to time, the Principal Lawyer will be the professional who regularly interacts with the Board, internal lawyers, and management personnel.

C. While it is anticipated that the GC may have multiple offices, the GC must maintain its principal offices in the Southern California area. The Principal Lawyer must be resident in one of the GC's Southern California offices.

III. Strategic Duties.

A. The GC will regularly provide the Board and management with reports on legal trends, issues, and best practices in California and across the healthcare industry, particularly in the public sector domain, that may materially affect CalOptima's business and mission, both currently and in the future.

B. The GC will regularly meet and confer with the Board and management to support CalOptima's strategic planning efforts as an integral member of CalOptima's senior management staff.

IV. Governance Duties.

A. The GC will report to the Board and shall attend all regular and special meetings of the Board, as well as other Board committee meetings by request.

B. The GC will work with internal lawyers to ensure compliance with all Public Laws related to CalOptima's governance.

B. The GC will work with internal lawyers to provide the Board with written summaries of all material legal issues concerning the agency on a regular basis, for monthly board meetings at a minimum.

V. Health Care and Privacy Oversight Duties.

A. The GC will work with CalOptima's compliance personnel and internal lawyers to establish and periodically update CalOptima's health care compliance programs and policies.

B. The GC will regularly attend CalOptima compliance committee meetings.

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C. The GC will work with internal lawyers to engage, assist and manage outside compliance counsel and other consultants and support personnel as may be needed from time to time, in connection with investigations, audits, responses to regulatory authorities, and other compliance matters that are not routine.

D. The GC will periodically report to the Board and management regarding any material compliance issues.

VI. Managed Care Regulatory Duties.

A. The GC will work with internal lawyers and outside counsel, where necessary, to ensure compliance with all regulatory requirements of the California Department of Health Care Services, the California Department of Managed Health Care, the federal Center for Medicare & Medicaid Services, and any other governmental entities with jurisdiction over the agency.

B. The GC will periodically report to the Board and management regarding any material regulatory issues.

VII. Managed Care Operations Duties.

A. The GC will work with internal lawyers to ensure that all legal issues related to CalOptima's managed care operations ("Operations Issues") are handled and resolved in a timely and appropriate manner. Operations Issues may involve a broad range of subject matter areas, including without limitation general business operations, payor and provider contracting, credentialing and administration, utilization review and quality assurance, member grievance resolution, provider dispute resolution, vendor contracting, procurement, real estate, intellectual property and technology, Public Laws, risk management and insurance, labor and employment, and general litigation.

B. The GC will work with internal lawyers to engage, assist and manage outside counsel and other consultants and support personnel as may be needed from time to time, to provide legal services in connection with Operations Issues.

C. The GC will periodically report to the Board and management regarding any material Operations Issues affecting the agency.

VIII. Management Duties.

A. The GC will be responsible for managing the overall legal affairs of the agency and coordinating the activities of the internal lawyers and outside legal counsel.

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B. ~~The GC will regularly advise the Board about the status of any material legal issues affecting the agency, and will be expected to keep the Board apprised of any legal issues that could adversely or positively affect CalOptima activities.~~

Board of Directors Meeting
March 4, 2021

Provider Advisory Committee Update

On February 11, 2021, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Richard Sanchez, Chief Executive Officer, provided a CEO report and notified the committee of the Board's request that the PAC (along with other Board advisory committees) review certain items as part of the Strategic Plan update. PAC agreed to extend the timeframe of the joint meeting scheduled for March 11, 2021 to allow time to review the Board's request and to provide feedback from all Board committees. Mr. Sanchez also notified the committee that the Member Representative seat on the Board had been filled.

Ladan Khamseh provided a Chief Operating Officer report and updated the PAC members on the current status of the Qualified Medicare Beneficiary Program to claim Part A Medicare benefits.

Emily Fonda, Interim Chief Medical Officer, provided an update that included information on the current status of the E-Consult/Telehealth. In addition to her CMO Report, Dr. Fonda provided a comprehensive COVID-19 update.

Rachel Selleck, Executive Director, Public Affair, presented on the current strategic plan and noted that the PAC members had received details on the current status of each initiative as part of their meeting materials. She also noted that staff was preparing information for the advisory committees and their joint meeting. Ms. Selleck also provided the PAC with a Federal and State Legislative update.

PAC member, Jennifer Birdsall Ph.D., Chief Clinical Officer with CHE Behavioral Health Services, who represents the Allied Health providers, gave a presentation on Meeting the Mental Health Services Needs of Persons in the Community and Long-Term Care Settings.

Pallavi Patel, Director, Process Excellence, provided PAC members with an update on the California Advancing and Innovating Medi-Cal (CalAIM) initiative and noted that CalAIM is currently scheduled to begin on January 1, 2022.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Board of Directors Meeting
March 4, 2021

Member Advisory Committee Update

February 11, 2021

At the February 11, 2021 Member Advisory Committee (MAC) meeting, members voted to approve the recommendation to appoint Linda Adair Pugh to the MAC as the Medi-Cal Beneficiaries Representative.

Richard Sanchez, Chief Executive Officer, notified the committee that the Member Representative seat on the Board had been filled. Mr. Sanchez also discussed the Board's request that the MAC (along with other Board advisory committees) review certain items as part of the Strategic Plan update. MAC agreed to extend the timeframe of the joint meeting scheduled for March 11, 2021 to allow time to review the Board's request and to provide feedback from all Board committees.

Ladan Khamseh, Chief Operating Officer, updated the MAC on the Qualified Medicare Beneficiary outreach that began earlier in November. Ms. Khamseh noted that over 40% of CalOptima members had responded to the letters that were sent notifying certain members that they may qualify for Medicare Part A benefits.

Emily Fonda, M.D., Interim Chief Medical Officer, provided an update on the E-Consults/ Telehealth initiative. She also provided a comprehensive COVID-19 presentation that generated questions and discussion among MAC members.

Debra Kegel, Director, Strategic Development, provided an update to the current strategic plan and discussed how staff was preparing items for the joint meeting of the advisory committees to assist with the request from the Board. Ms. Kegel noted that MAC members had received a copy of the status report on the strategic plan initiatives in the meeting materials.

MAC members also received a presentation from fellow MAC member Hai Hoang, Chief Operating Officer of Illumination Institute on Children with Intellectual/Developmental Disabilities - Reaching the Underserved. In addition, Tiffany Kaaiakamanu, Manager, Community Relations, updated the MAC on how CalOptima's Community Relations Department was outreaching during the current pandemic. Jackie Mark, Sr. Policy Advisor, Government Affairs, also provided the MAC with a Federal and State Legislative update.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's current activities.

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