NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

APRIL 6, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Blair Contratto, Vice Chair
Isabel Becerra	Supervisor Doug Chaffee
Clayton Chau, M.D.	José Mayorga, M.D.
Supervisor Vicente Sarmiento	Nancy Shivers, R.N.
Trieu Tran, M.D.	Vacant

Supervisor Donald Wagner, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	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 Health, 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 Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_RNXGuqmSRwShZyX7KuOBAg and Join the Meeting.
Webinar ID: **894 4614 7138**
Passcode: **678054** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Street Medicine Update

MANAGEMENT REPORTS
2. Chief Executive Officer Report

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 March 2, 2023 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the November 17, 2022 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and the Minutes of the December 14, 2022 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

4. Receive and File 2022 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation and Approval of the 2023 CalOptima Health Program of All Inclusive Care for the Elderly Quality Improvement Plan

5. Receive and File 2022 CalOptima Health Quality Improvement Program Evaluation and Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan

6. Approval of Revision to the Measurement Set for the CalOptima Health Measurement Year 2023 Medi-Cal Quality Pay for Value Program

7. Approval of New CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

8. Authorize and Direct Execution of Amendment(s) to CalOptima Health's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

9. Appointment to the CalOptima Health Board of Directors' Member Advisory Committee

10. Authorize Staff to Modify CalOptima Health's Whole-Child Model Family Advisory Committee Reporting Structure

11. Receive and File:
    a. February 2023 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

12. Approve Amendments to the CalOptima Health Bylaws

13. Approve CalOptima Health's Calendar Years 2023 and 2024 Legislative Priorities and Authorize Related Advocacy Efforts

14. Approve Actions Related to CalOptima Health Medi-Cal and the Program of All-Inclusive Care for the Elderly Disposable Incontinence Supplies Vendors

15. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ironwood Health LLC to Provide Professional Services for the Implementation of the New Clinical Care Management System

16. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ankura Consulting Group, LLC to Provide Professional Services for Credentialing Process Review and Proposed Budget Allocation Changes in the CalOptima Health Fiscal Year 2022-23 Operating Budget

17. Approve New CalOptima Health Policy MA.2017p: Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents

18. Approve New CalOptima Health Policy MA.7020p: Behavioral Health Services

CLOSED SESSION

CS-1. Pursuant to Government Code Section 54956.75 (a) – Discuss Confidential Final Draft from the Bureau of State Audits

CS-2. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8
Under Negotiation: Price and terms of payments
Property: 14851 Yorba Street & 165 N. Myrtle Avenue, Tustin, CA 92780
Agency Negotiator: David Kluth, John Scruggs, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Yorba Myrtle LLC

CS-3. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8
Under Negotiation: Price and terms of payments
Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841
Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Lvt, Inc.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on April 6, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_RNXGuqmSRwShZyX7KuOBAg

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/89446147138?pwd=ZkdJVU9tdEEvR0NKR0Mzdm5DbmZPQT09

Passcode: **678054**

Or One tap mobile:
+16694449171,,89446147138#,,,,*678054# US
+13462487799,,89446147138#,,,,*678054# US (Houston)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 346 248 7799 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799

Webinar ID: 894 4614 7138
Passcode: 678054
International numbers available: **https://us06web.zoom.us/u/koZC8JLli**

Street Medicine Overview

Board of Directors Meeting

April 6, 2023

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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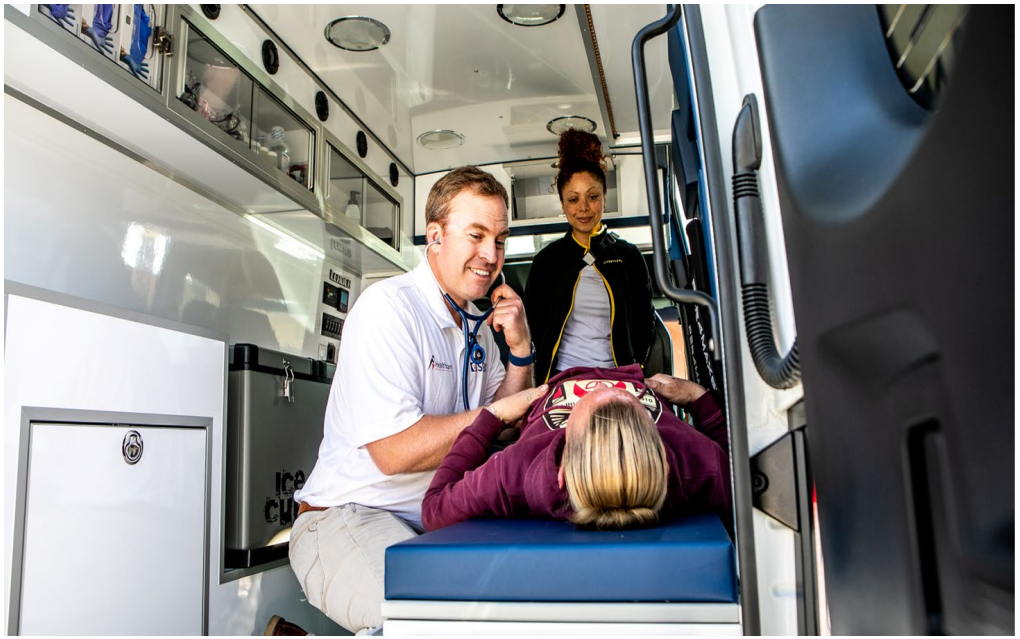
Street Medicine Program Goal

To reduce barriers to quality medical care and improve the health outcomes for Garden Grove's unsheltered population by delivering compassionate and respectful medical care through direct street outreach and engagement.



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CalOptima Health

Program Objectives

- Provide 200 participants with point of care medical services reducing ED visits by 40%
- Enroll 75% of unenrolled eligible participants into Medi-Cal CalOptima Health
- Connect 25% of participants to a Medical Home
- Connect 80% of participants with ECM or Community Support Services
- Transition 25% participants to a shelter or other housing option

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CalOptima Health

Program Model

- Trauma Informed Care Philosophy
- Canvassing Approach
- Comprehensive Medical and Social Care
  - Medical Care Team
  - Coordination Care Team

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CalOptima Health

Services Provided

- Medical Care Team
  - Primary Medical Care
    - Labs
    - Prescribe medications
    - Refer to specialist
    - Ongoing care (PCP)
  - Urgent Care
- Coordination Care Team
  - Provide regular face-to face visits
  - Schedule medical appointments
  - Housing Navigation
  - Enhanced Care Management

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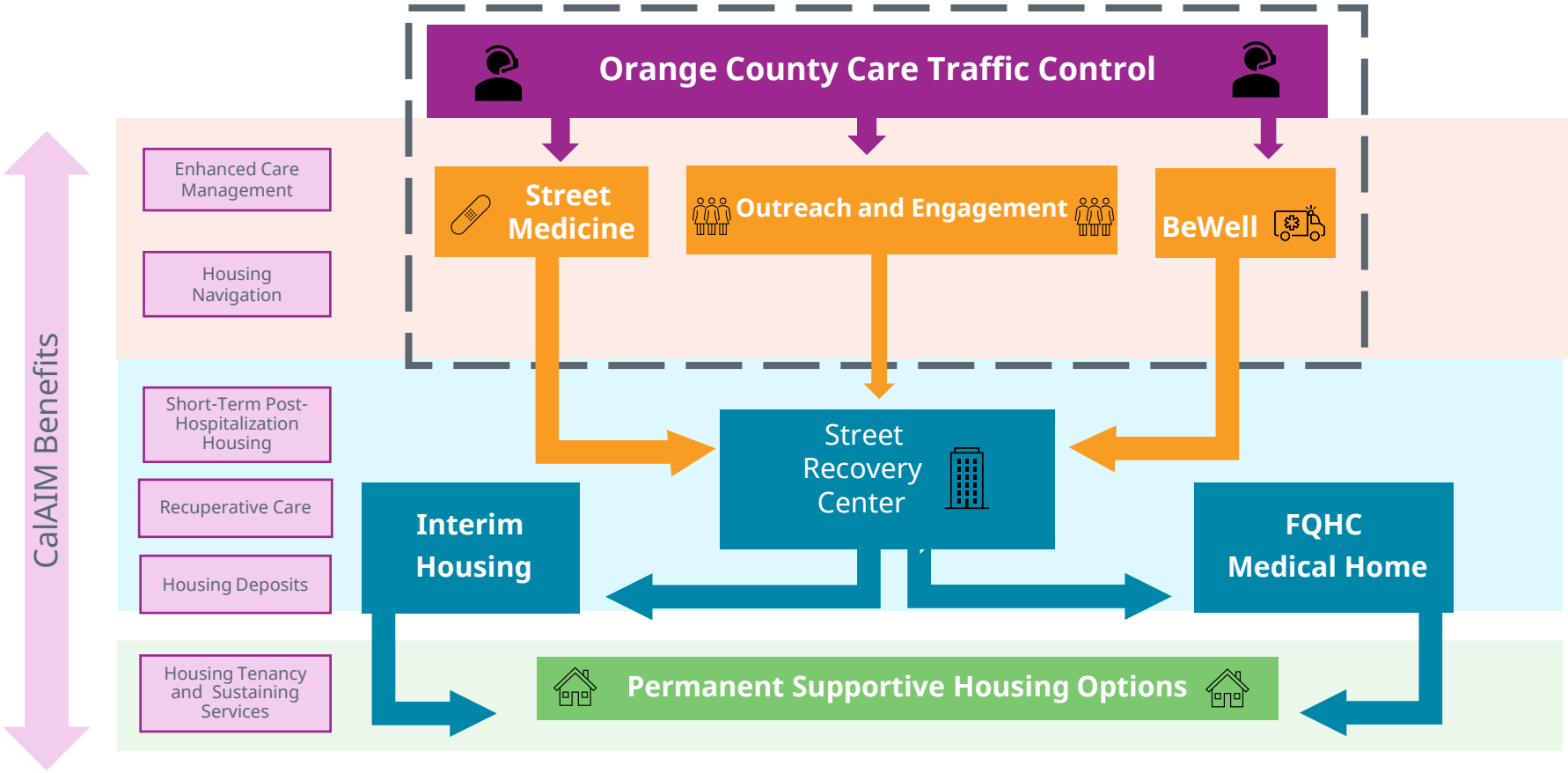
CalOptima Health

Street Medicine and Outreach Program



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CalOptima Health

Stakeholders

- **Garden Grove Police and Orange County Fire Authority –** Identify hot spots and encampments and make referrals
- **CalOptima Health CalAIM Team –** Day to Day Administration of the program
- **Healthcare in Action –** Street Medicine Provider
- **Be Well OC –** Mental Health crisis stabilization and make referrals
- **Orange County Health Care Agency (HCA) –** Make referrals and collaborating partner
- **Families Together Orange County (FQHC) –** Medical Home and PCP provider
- **ExamMed –** Technology platform to integrate and coordinate care on the street within minutes of engagement

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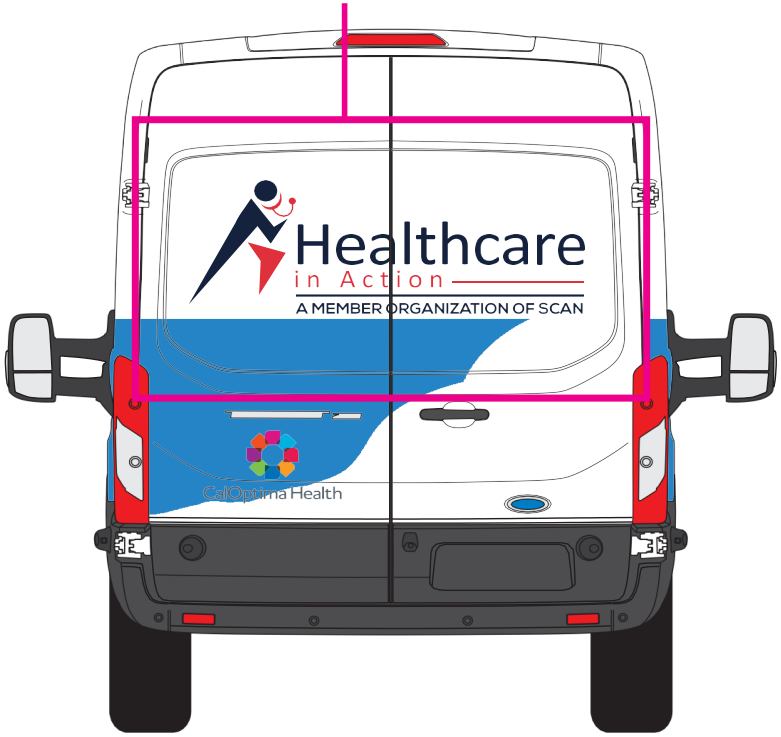

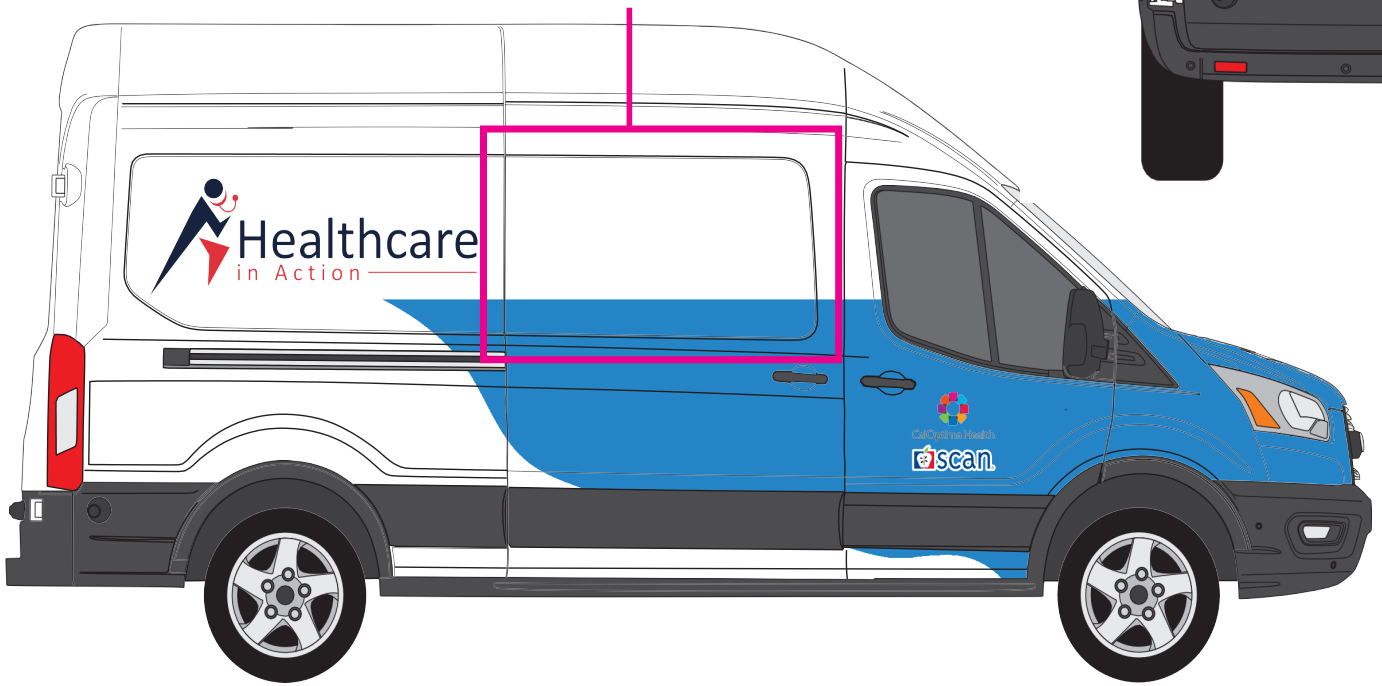

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MEMORANDUM

DATE:	March 30, 2023
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — April 6, 2023, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

a. <u>Street Medicine Program Launches April 1</u>

The first-of-its-kind program in Orange County, CalOptima Health's Street Medicine Program is designed to improve health outcomes by connecting primary care providers with individuals experiencing homelessness to build long-term relationships and trust that ultimately will result in secure housing. Contracted street medicine provider Healthcare in Action will use a mobile doctor's office to canvas the Garden Grove community and reach members living in parks, under freeways or other unsheltered spaces. Services will include primary care, behavioral health and case management but also the expanded whole-person care resources now available through CalAIM.

- **Presentation to Garden Grove City Council**
  Kelly Bruno-Nelson, Executive Director of Medi-Cal/CalAIM, and I presented an overview of our Street Medicine Program at a Garden Grove City Council meeting in March. We shared information about the evidence-based philosophy behind this program and expected outcomes.
- **Media Event**
  On April 4, CalOptima Health, in partnership with the City of Garden Grove and Healthcare in Action, will hold a media event to announce the start of the program. The event will include remarks from leaders of the partnering organizations, a look inside the mobile doctor's office van and an opportunity for the media to speak with street team staff.

b. <u>Medi-Cal Renewal (Re-determination) Outreach and Communications Continue</u>

- **InfoSeries**
  CalOptima Health held a virtual InfoSeries on Medi-Cal renewal that attracted more than 400 health care professionals and community stakeholders on March 29 and 30. The meeting included speakers from the County of Orange Social Services Agency (SSA), Covered California and CalOptima Health and provided info on the renewal process and community resources.
- **Communications Toolkit**
  CalOptima Health's communications multilingual toolkit is on our website for community use at www.caloptima.org/en/Renew/Toolkit. These materials are co-branded with SSA, which also intends to use these same resources to ensure message alignment.

- **Community Navigator Request for Proposal (RFP)**
  CalOptima Health received eight proposals in response to the RFP for community navigator services to support Medi-Cal renewal and CalFresh enrollment. An evaluation team will review and score the proposals with the intent of identifying organizations to engage as soon as possible.
- **Member Engagement Tool**
  CalOptima Health contracted with a specialized technology vendor to supply a member engagement tool that will support Medi-Cal renewal communications, including texting, emails and robocalls. Our ITS and Communications teams will collaborate on the use of the tool and work in partnership with SSA to coordinate our outreach to members.

c. DHCS Audit of PACE to Begin April 10

The Department of Health Care Services (DHCS) will be conducting a routine audit of the CalOptima Health Program of All-Inclusive Care for the Elderly (PACE). The following areas are included in the scope of the audit: grievance documentation procedures, clinical appropriateness and care planning, transportation, personnel records, subcontractor agreements, serious incident reports, on-site review of the facility, emergency preparedness, and meal preparation and kitchen procedures. The on-site review will be conducted from April 10–21. The most recent prior audit of PACE was in 2018. CalOptima Health anticipates it will also receive an engagement notice from the Centers for Medicare & Medicaid Services (CMS), in which case CMS would conduct a similar but separate audit at the same time as the DHCS audit.

d. CalOptima Health Welcomes New Chief Strategy Officer

Peter Bastone has joined CalOptima Health as Chief Strategy Officer. In this new role, Bastone will share his insight and experience as he works with the executive team to develop and execute our overall strategic planning efforts and key policy initiatives. Peter is a well-known and respected healthcare leader and strategist to our network providers, delegated medical groups, acute care providers, and physicians. Most recently, he was the Corporate Vice President and COO of KPC Health and previously spent 15 years at St. Joseph Health, serving as President and CEO of Mission Hospital Regional Medical Center in Mission Viejo and Laguna Beach. He has also held executive leadership positions in hospitals, health systems and health impact foundations in New Mexico and Virginia. Bastone has a bachelor's degree in Physiological Psychology from Princeton University, a master's degree in public health/Corporate Management from UC Berkeley, and a master's degree in Theology and Health Care Mission from Aquinas Institute of Theology in St. Louis.

e. CalOptima Health Welcomes New Sr. Director of Federal and Local Government Affairs

Jordan Abushawish has joined CalOptima Health as Sr. Director of Federal and Local Government Affairs, with responsibility for expanding our engagement with federal and local elected offices and agencies. Jordan has more than 15 years of experience in representing health care organizations with a focus on legislative strategy, policy development and government relations. Most recently, he was Director of Government and Public Affairs at Providence Health and Services in Irvine. He has a bachelor's degree in political science from UC Riverside and a Master of Public Policy (MPP) degree from Pepperdine University.

f. Meetings Held with DHCS and Medi-Cal Managed Care Plans

In March, I traveled to Sacramento with Chief Financial Officer Nancy Huang and Eric Rustad, Executive Director, Finance, to attend meetings with the CEOs and CFOs of Medi-Cal managed care

plans and leaders at DHCS. Collectively, the CEOs expressed concerns about the resumption of Medi-Cal redeterminations and reiterated the need for data sharing between counties and plans. DHCS stated that it will be contacting counties soon to provide data-sharing guidance and to encourage the execution of agreements. Other topics discussed include CalAIM, ongoing quality sanction appeals, and upcoming grants for small- and medium-sized providers. Following the DHCS meeting, I met with the chief of staff for newly elected State Assemblywoman Blanca Pacheco, who represents a small area of north Orange County, to highlight CalOptima Health's role in the community.

g. CalOptima Health Makes New Request for Fiscal Year (FY) 2024 Federal Earmarks

CalOptima Health has submitted two FY 2024 federal earmark requests to Orange County's Congressional delegation. First, we re-submitted a modified proposal to permanently extend and expand street medicine beyond the pilot program in Garden Grove. Sen. Alex Padilla sponsored our Street Medicine Pilot Program earmark request last year, but it was not included in the final FY 2023 federal appropriations bill. Second, we submitted a new earmark request to help establish our Community Living Center in Tustin. We are proud to have received support letters from four supervisors and 11 state legislators representing Orange County. In the coming weeks, Congressional offices will notify applicants about which projects are being sponsored. Relatedly, staff is currently working through the U.S. Department of Health & Human Services disbursement process to receive the enacted FY 2023 earmark of $2 million to help launch our Care Traffic Control initiative, which was sponsored by U.S. Reps. Lou Correa and Young Kim.

h. March Press Releases Generate Robust Media Engagement

The following press releases were distributed to the media in March and resulted in major online, print and radio coverage. Links to selected coverage are below.

- **CalOptima Health Awards $29.9 Million in Grants to Boost Services for Orange County's Homeless**
  March 8 — CalOptima Health announced the community grants awarded as part of our participation in the Housing and Homelessness Incentive Program (HHIP). A total of 29 organizations received $29.9 million, including CalOptima Health's first-ever funding for permanent supportive housing.
  Coverage —Voice of OC (March 8), PhilanthropyNewsDigest.com (March 14) and Orange County Register (March 20)
- **CalOptima Health Warns Members About Unauthorized Door-to-Door Solicitors**
  March 14 — CalOptima Health warned members about unauthorized solicitors visiting members at their homes. These individuals are misrepresenting themselves as CalOptima Health employees offering free wireless phones and asking for private information.
  Coverage — Daily Pilot (March 15) and KFI radio (March 16)
- **Medi-Cal Renewals Will Impact Nearly 1 Million Orange County Residents**
  March 21 — CalOptima Health highlighted that Medi-Cal renewals are set to begin in April. The annual renewal process, which was suspended during the pandemic, could result in thousands of people losing their health care coverage.
  Coverage — This press release was issued as a follow-up to prior coverage and to continue raising awareness. Orange County Register (and all Southern California News Group papers on February 27) and Voice of OC (March 7).

CalOptima Health

Fast Facts
April 2023

Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.

Membership Data* (as of February 28, 2023)

Total CalOptima Health Membership

976,552

Program	Members
Medi-Cal	958,778
OneCare (HMO D-SNP)	17,342
Program of All-Inclusive Care for the Elderly (PACE)	432

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for eight months ended February 28, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$2,621,579,775	$2,673,516,085	($51,936,310)
Medical Expenses	$2,424,662,289	$2,500,925,224	$76,262,935
Administrative Expenses	$119,454,202	$142,318,218	$22,864,016
Operating Margin	$77,463,284	$30,272,643	$47,190,641
Medical Loss Ratio (MLR)	92.5%	93.5%	(1.1%)
Administrative Loss Ratio (ALR)	4.6%	5.3%	0.8%

Reserve Summary (as of February 28, 2023)

	Amount (in millions)
Board Designated Reserves	$569.9*
Capital Assets (Net of depreciation)	$67.1
Resources Committed by the Board	$446.9
Resources Unallocated/Unassigned	$436.1*
Total Net Assets	$1,520.0

Total of Board designated reserves and unallocated resources can support approximately 101 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

NOTE: CalOptima Health receives its funding from State and Federal revenues only. CalOptima Health does not receive any of its funding from the County of Orange.

CalOptima Health Fast Facts

April 2023

Personnel Summary (as of March 11, 2023, pay period)

	Filled	Open	Vacancy %
Staff	1,266.4	132.5	9.47%
Manager	102.0	13.0	11.30%
Director	54.5	12.0	18.05%
Executive Director	11.0	1.0	8.33%
Chief	9.0	1.0	10.00%
Total FTE Count	1,442.9	159.5	11.05%

FTE Count based on position control reconciliation and includes both medical and administrative positions.

Provider Network Data (as of February 28, 2023)

	Number of Providers
Primary Care Providers	1,291
Specialists	8,194
Pharmacies	567
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	99

Treatment Authorizations (as of January 31, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	12.96 hours
Prior Authorization – Urgent	72 hours	17.69 hours
Prior Authorization – Routine	5 days	1.43 days

Average turnaround time for routine and urgent authorization requests for CalOptima Health Community Network.

Member Demographics (as of February 28, 2023)

Member Age	
0 to 5	8%
6 to 18	25%
19 to 44	35%
45 to 64	20%
65 +	12%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

March 2, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on March 2, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. Acting Chair Corwin called the meeting to order at 2:02 p.m. and welcomed new CalOptima Health Board member, Supervisor Vicente Sarmiento to the Board of Directors. Supervisor Sarmiento led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Acting Chair; Isabel Becerra; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga M.D.; Supervisor Vicente Sarmiento; Nancy Shivers; Trieu Tran, M.D. (at 2:08 p.m.)

(All Board Members participated in person except Director Shivers, who participated remotely under Just Cause, using her first use of two under Just Cause as a result of AB 2449)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer (CEO), welcomed Supervisor Vicente Sarmiento to the CalOptima Health Board. He noted that Supervisor Sarmiento is a former mayor of Santa Ana and familiar with the magnitude of care provided by CalOptima Health for the residents of that city.

Mr. Hunn reviewed the Fast Facts data as of January 2023 and noted that CalOptima Health currently serves 973,571 individuals, with a $4 billion-dollar budget, which is 90% state funded and 10% federally funded. He noted that CalOptima Health receives no funding from the County of Orange.

For the current fiscal year, CalOptima Health spends 93.3% of every dollar on medical care, and 4.5% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $573.8 million; its capital assets are $67 million; its resources committed by the Board are $448.1 million; and its unallocated and unassigned resources are $409.9 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.4 billion.

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Mr. Hunn also reviewed the CalOptima Health personnel data and noted there are 1,506 employees with a vacancy/turnover rate of about 10.7%, stating that CalOptima Health's vacancy/turnover target is to be at less than 12.5 to 15% at any given time. He noted that at this time last year, CalOptima Health had about a 20% vacancy/turnover rate, so significant progress is being made both in recruiting and filling positions and also in retaining highly qualified and sought-after individuals.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has over 10,000 providers, 1,293 primary care providers, and 8,160 specialists; 565 pharmacies; 45 acute and rehab hospitals; 34 community health centers; and 98 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that this data is as of December 31, 2022. For urgent inpatient treatment authorizations, the average approval is within 14 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 16 hours; the state-mandated response is 72 hours. And for routine prior authorizations the average approval is 1.6 days; the state-mandated response is 5 days. Mr. Hunn again complimented CalOptima Health's utilization management team and its medical directors for the incredible work being done to ensure the authorizations as processed as efficiently as possible.

Mr. Hunn also provided updates on Medi-Cal redetermination. With the ending of the federal public health emergency (PHE), the state estimates that about 20% of individuals may lose their eligibility during redetermination for Medi-Cal services. He noted that staff is working closely with the Social Services Agency (SSA) to help individuals navigate these upcoming changes. Mr. Hunn shared three key messages for members of the public who will be affected by redetermination: (1) to be on the lookout for their letter, if the individual recalls the month in which they were originally eligible, that will be the month they will go through redetermination; (2) to make sure that their demographic information is up-to-date in SSA's system (name, address, phone numbers, and email address); and (3) once the individual receives their packet, they will have approximately 60 days to complete the forms and return them for redetermination.

Mr. Hunn reported that CalOptima Health is going through its annual routine medical audit performed by the Department of Health Care Services (DHCS). John Tanner, Chief Compliance Officer, provided a brief update, noting that CalOptima Health has concluded the webinar and interviews portion of the routine medical audit. Mr. Tanner commented that the audit started on Monday, February 27, 2023, and CalOptima Health received news this afternoon that the audit has gone smoothly and DHCS is continuing to review the materials. Mr. Tanner also reported that CalOptima Health has received notice that its Program of All-Inclusive Care for the Elderly (PACE) will go through a routine audit conducted by DHCS from April 10 through April 20, 2023.

Mr. Hunn thanked CalOptima Health Chief Medical Officer Dr. Richard Pitts, Deputy Chief Medical Officer Dr. Zeinab Dabbah, and the ten other CalOptima Health medical directors, noting that the work they do is quite extraordinary. He also noted that CalOptima Health is fortunate to have such dedicated and experienced physicians in leadership roles covering vast areas of health care, including care management, utilization review, internal medicine, neurosurgery, cardio-thoracic surgery, transplant surgery, complex cancer surgeries, family practice, pediatrics, preventive medicine, psychiatry, and general medicine.

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Kelly Bruno-Nelson, Executive Director, CalAIM, provided an overview of the Housing and Homelessness Incentive Program (HHIP), which as previously reported to the Board, allows CalOptima Health to earn incentive funds for making investments and progress in addressing homelessness. Ms. Bruno-Nelson shared that today CalOptima Health is recommending approval of 31 grant applications funded through the HHIP. The grants were selected in support of CalOptima Health's CalAIM initiatives with the purpose of identifying and managing comprehensive needs through whole-person care approaches. In order to do this, CalOptima Health executed and implemented 14 community supports, as well as enhanced case management. Ms. Bruno-Nelson noted that CalOptima Health itself does not provide those services but partners with community-based organizations to provide those services.

She reviewed the timeline that led to up to the selection of proposed grantees, including the release of the notice of funding opportunity in January, review of the proposals with a large committee in February, and today's recommendations to the Board for awarding grant funding. Ms. Bruno-Nelson also reviewed the scoring criteria, which included ensuring that the applications aligned with CalOptima Health's core values, ensuring that the objectives and the outcomes were clear, sustainable, and ready for implementation, and also noted that the organizations had the expertise to provide the services and had the financial and management capacity to carry out the projects. She reported that CalOptima Health received 65 applications from 45 different non-profit organizations and is recommending approval of 31 grant applications. Ms. Bruno-Nelson noted that CalOptima Health received three different types of grant applications: capacity grants, building capital grants, and equity grants. She reviewed the descriptions of the different types of grants and the total number of each type of grant and the funding associated with each of the proposed 31 grant applications. Ms. Bruno-Nelson also reviewed the grants that were denied and the reasons for the denial, noting that CalOptima Health personally called each organization to inform the agency of the denial of their application and offer assistance in applying for the next round of grants. She added that the calls went very well. Ms. Bruno-Nelson noted that this first round of grants also provided some lessons learned and opportunities for improvement, which included providing technical assistance sessions for some of the non-profit organizations and allowing grantees more time to answer the applications. Lastly, she added that the approval of the grant applications is Report Item 9 on today's agenda but wanted to highlight this during the CEO Report given the magnitude and importance the HHIP grants.

Mr. Hunn welcomed back to CalOptima Health Javier Sanchez, Executive Director, Medicare Programs. He also welcomed Chief Strategy Officer Peter Bastone.

Mr. Hunn noted that March 3, 2023, will mark one year since being appointed permanent CEO at CalOptima Health. He reviewed a comprehensive list of CalOptima Health accomplishments during the last year, noting that none of them could have happened without the support of the Board and the incredible people sitting in the room that he has the privilege of working with. Mr. Hunn noted that the accomplishments could not have happened without the input received from CalOptima Health's community-based organizations, key stakeholders, community clinics, federal qualified health centers, provider partners, children's provider partners, elected officials, health care partners, and colleagues across the county. He added that most importantly, the feedback received from individuals and members every single day helped CalOptima Health to achieve the many accomplishments over the past year, which include fielding 40,000 calls a month; launching CalAIM with all 14 community supports; rebranding of CalOptima to CalOptima Health, including name, logo, mission and vision statement; establishing a new strategic plan and tactical priorities approved by the Board; updating CalOptima

Health's Bylaws; appointing general counsel outsourced legal services; filling all medical director positions; improving CalOptima Health's overall turnover rate; clearing a 15,000 treatment authorization backlog; launching Information Technology Services digital transformation to improve infrastructure and security; and the Board's approval and investment of $462 million dollars from CalOptima Health reserves to fund various incentive programs. The incentive programs include a 5-year hospital quality program, a community click value-based program, reallocation to fund related homeless initiatives, cancer screening program, increased rates for applied behavioral analysis providers, and support for the Be Well OC campus. The above list is a sample of CalOptima Health's accomplishments in the last 12 months with the support of the Board, community-based organizations, delegated health network, acute care providers, medical groups, physicians, elected officials, and most importantly, its members. Mr. Hunn added that is has been and continues to be a privilege to serve as CalOptima Health's CEO.

Director Contratto noted that it has been a remarkable first year on the CalOptima Health Board and that she is deeply thankful to Mr. Hunn for his leadership and the growth in core initiatives and support of the strategic plan and mission. She also noted that, from a Board perspective, having such high caliber professionals guiding this organization and willing to be completely transparent with the Board is so valuable.

Acting Chair Corwin added to Director Contratto's comments noting that over the past year he has observed the inclusiveness in terms of collaboration across all sectors, which leads to the best decisions and to a renewed and more positive culture at CalOptima Health that gets things done as opposed to trying. Leadership has planted a lot of seeds over the last year, and there is a lot of work ahead. It will be exciting to see the execution over the next year or two.

PUBLIC COMMENTS

There were no public comments.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the February 2, 2023 Regular Meeting of the CalOptima Health Board of Directors

Supervisor Sarmiento announced his recusal on Consent Calendar Item 2 as he was not in attendance at the February 2, 2023 Board of Directors meeting.

3. Approve New CalOptima Health Policy GG.1213: Community Health Worker Services

4. Approve New CalOptima Health Grievance and Appeals Resolution Services Policy MA.9015p

5. Authorize Proposed Budget Allocation Change in the CalOptima Health Fiscal Year 2022-23 Operating Budget for Cultural & Linguistic Expenses

6. Approve CalOptima Health Position on Proposed Legislation

7. Receive and File:

a. January 2023 Financial Summary

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

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 8-0-0 except as noted above; Supervisor Sarmiento recused on Consent Calendar Item 2)***

REPORTS/DISCUSSION ITEMS

8. Consider Election of Officers of the CalOptima Health Board of Directors

Director Becerra made a motion to elect Acting Chair Corwin to serve as Chair and Director Contratto to serve as Vice Chair.

Supervisor Chaffee made a motion that Acting Chair Corwin remain Acting Chair for the remainder of the term and hold elections as scheduled at the organizational meeting.

Supervisor Sarmiento asked for clarification on whether Supervisor Chaffee's was a substitute motion, noting he was not sure if the Board follows Roberts Rules or Parliamentary Procedure.

General Counsel, James Novello responded that a second vote should be taken for the proposal and noted that the votes for each seat should be separate. The first vote for the election of the Chair and then the second vote for the election of the Vice Chair.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors Elected Acting Chair Clayton Corwin to serve as Chair of the CalOptima Health Board of Directors through June 30, 2023, or until such time as a successor(s) is elected, unless he, she, or they shall sooner resign or be removed from office. (Motion carried 6-0-2; Supervisors Chaffee and Sarmiento abstained)***

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors Elected Director Blair Contratto to serve as Vice Chair of the CalOptima Health Board of Directors through June 30, 2023, or until such time as a successor(s) is elected, unless he, she, or they shall sooner resign or be removed from office. (Motion carried 6-0-2; Supervisors Chaffee and Sarmiento abstained)***

9. Approve Actions Related to the Housing and Homelessness Incentive Program

Director 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 Contratto commented that she had a chance to meet with Ms. Bruno-Nelson and her team to review all of the recommended grant recipients as well as the process staff used to solicit and evaluate the grants. She noted that the level of detail that Ms. Bruno-Nelson and her team have gone through to engage the community to put meaningful funds into CalOptima Health's commitment for homeless

housing is remarkable.

Director Sarmiento noted that he felt uncomfortable voting on such a large item like this with him being so new on the Board, but acknowledged its importance. He thanked staff for briefing him earlier in the week, noting that he is trying to learn about the HHIP. Supervisor Sarmiento also noted that he is a big believer in building organizational capacity and as a former mayor of Santa Ana, he had the blessing of working with many of the organizations that provide services to many residents in not only the city, but in District 2. He added that as CalOptima Health goes into the second round of awarding grants, that it should feel free to lean on Supervisor Sarmiento's office to assist in working with organizations in the District and the county.

Director Chau requested that Ms. Bruno-Nelson and her team, work with the county's Equity in OC team because the county also funds organizations for capacity building. This will help to avoid duplication of efforts, especially when there is another round of capacity building the county is going to release very soon.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved CalOptima Health staff recommendations to administer grant agreements and award payments to selected grant recipients (listed in Attachment 2) for each of the following funding areas, as a result of the notice of funding opportunity as follows: a.) Infrastructure Projects that will increase housing navigation and organizational capacity to connect individuals to permanent supportive housing: i.) Total of payments recommended for award: $5,832,314. b.) Capital Projects to increase the current affordable and permanent housing pool: i.) Total of payments recommended for award: $21,000,000. c.) Equity Grants for Programs Serving Underrepresented Populations of people experiencing homelessness: i.) Total of payments recommended for award: $3,021,311. 2.) Approved reallocations to the Capital Projects priority area: a.) $4,667,686 from Infrastructure Projects; and b.) $1,978,689 from Equity Grants for Programs Serving Underrepresented Populations. 3.) Approved allocation of up to $12.6 million in HHIP funding from the California Department of Health Care Services (DHCS) to the Capital Projects priority area. (Motion carried 7-0-0; Directors Becerra recused)***

10. Authorize Insurance Policy Procurements and Renewals for Policy Year 2023-24

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Authorized procurement and renewal of insurance policies for policy year 2023-24 at a premium cost not to exceed $4,500,000; and 2.) Delegated authority to the Chief Executive Officer to approve future policy renewals when there are no significant changes to expiring coverage terms and conditions, and no additional coverage types to consider. (Motion carried 8-0-0)***

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11. Authorize Implementation of a Contract with Varis LLC and Amendment to the Contract with Cotiviti, Inc.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors: Authorized the Chief Executive Officer to: 1.) Offer a contract to Varis LLC (Varis) at a flat per case pricing for claims overpayment forensic review for an initial term of three years, starting September 25, 2023, through September 24, 2026, with two one-year extension options, exercisable at CalOptima Health's sole discretion. Should this offer be declined by Varis, a contract with the secondary selected vendor, Cotiviti, will be proposed for the same period. 2.) Effective upon Board approval, amend the contract with Cotiviti, Inc. (Cotiviti) for claims editing services to transition from a contingency fee contract to a per member per month (PMPM) service fee contract and move to the Payment Policy Management (PPM) claims editing software expected to be implemented in September 2023. (Motion carried 8-0-0)***

12. Approve Actions Related to the Procurement of a Modern Customer Contact Center Solution

Supervisor Sarmiento commented that he has a procedural concern with this item and with Agenda Item 13. He would like to make an amendment to staff's recommendation on this item that when CalOptima Health goes out to procure these services, that staff omit the language of "funds up to" as the agency loses leverage when soliciting bids. Supervisor Sarmiento added that the language could be redacted from the bid on this one and going forward not include "funds up to" and requested that staff include the criteria and weights when bringing these recommendations to the Board.

Yunkyung Kim noted that the requests for proposals (RFPs) do not go out with "funds up to" language nor is a budget ceiling noted in the RFPs. For this item, the "funds up to" is already out in the public sphere. Ms. Kim clarified that Supervisor Sarmiento would like to revisit the procurement process going forward so as not to limit the agency's ability to negotiate with vendors responding to these RFPs.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized reallocation of budgeted but unused funds up to $2.25 million to a new project "Modern Customer Contact Center Solution" under the "Infrastructure" category in the CalOptima Health Fiscal Year 2022-2023 Digital Transformation Year One Capital Budget. The reallocated funds will come from the following capital projects under "Applications Development" category: a.) $1.8 million from "Digital Transformation Strategy Planning and Execution Support"; and b.) $450,000 from "Migrate Data Warehouse Analytics to the Cloud." 2.) Approved the scope of work (SOW) for the Modern Customer Contact Center Solution. 3.) Authorized the Chief Executive Officer to release the approved SOW through a request for proposal (RFP) and to negotiate and contract with the selected vendor. (Motion carried 7-0-1; Supervisor Sarmiento abstained)***

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13. Approve Actions Related to the Procurement for the Member Mobile App

Supervisor Sarmiento noted for the record that he will abstain from voting on this item due to the "funds up to" language in the recommended action.

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors: 1.) Authorized reallocation of budgeted but unused funds up to $800,000 from the "Digital Transformation Strategy Planning and Execution Support" capital project to a new project "Member Mobile App" under the "Applications Development" category in the CalOptima Health Fiscal Year 2022-2023 Digital Transformation Year One Capital Budget. 2.) Approved the scope of work for a vendor to develop and support the Member Mobile App. 3.) Authorized the Chief Executive Officer to release the request for proposal, select a vendor, and negotiate and execute a contract with the selected vendor. (Motion carried 7-0-1; Supervisor Sarmiento abstained)***

14. Approve Actions Related to the Procurement of a Privileged Access Management Solution

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Approved the scope of work (SOW) for the Privileged Access Management (PAM) solution. 2.) Authorized the Chief Executive Officer to release the request for proposal (RFP), select a vendor, and negotiate and execute a contract with the selected vendor. (Motion carried 8-0-0)***

15. Authorize the Chief Executive Officer to Execute a Contract Amendment with Delphix Corp. to Procure and Implement a Data Masking Solution in Support of CalOptima Health's Digital Transformation Strategy

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized reallocation of budgeted but unused funds of $200,000 from Medi-Cal: Other Operating Expense Budget to fund the expansion of the Delphix Corp. (Delphix) contract with a Data Masking Solution; and 2.) Authorize the Chief Executive Officer to execute a contract amendment with Delphix to implement the Data Masking Solution. (Motion carried 8-0-0)***

ADVISORY COMMITTEE UPDATES

16. Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Update

Jena Jensen, Chair, Provider Advisory Committee (PAC) provided an update on the recent activities of the Joint Meeting of the Member Advisory Committee (MAC) and PAC. Ms. Jensen reported that there was much discussion around the state's redetermination efforts and getting information out to members. She also noted that the MAC and PAC will be approving candidates for several seats.

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Director Mayorga noted that the committees are very important and asked Ms. Jensen what the committees' biggest concerns are regarding redetermination. Ms. Jensen responded that the committee members want to make sure there is as little disruption as possible and to make sure that people are aware, receive their paperwork, and that there is enough staff at the state. Director Mayorga commented that the provider community shares their concerns.

Mr. Hunn added that staff has had many conversations with the MAC and PAC and with the SSA. He added that at the same time SSA is going through redetermination, the agency is also going through an agency-wide system upgrade, so this will add to an already complex process. CalOptima Health has invested $6 million to fund additional navigators to assist members with the redetermination process throughout Orange County.

Ms. Kim noted that CalOptima Health has been using the media to disseminate this information to members and ensure that both members and providers are aware of this redetermination process to better navigate the complexities.

Director Chau asked if the MAC and PAC could petition the state to tier the redetermination process to handle those that are currently in care and have chronic conditions first since they would be at the most risk if they lose eligibility.

The Board adjourned to Closed Session at 3:30 p.m.: (i) Pursuant to Government Code section 54956.8 CONFERENCE WITH REAL PROPERTY NEGOTIATIORS. Under Negotiation: Price and terms of payments, Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841, Agency Negotiator: David Kluth, and Mai Hu, Newmark Knight Frank, Negotiating Parties: Lvt Inc.; (ii) CONFERENCE WITH LEGAL COUNSEL – STRATEGY ON EXISTING LITIGATION, Pursuant to Government Code Section 54956.9(d)(1); (iii) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code Section 54956.9(d)(2):1 case; and (iv) CONFERENCE WITH LEGAL COUNSEL – PROACTIVE LITIGATION Pursuant to Government Code Section 54956.9(d)(4): 1 case.

The Board returned to Open Session at 4:45 p.m. and the Clerk reestablished a quorum.

ROLL CALL

Members Present: Clayton Corwin, Chair; Isabel Becerra; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga M.D.; Supervisor Vicente Sarmiento; Nancy Shivers; Trieu Tran, M.D.

(All Board Members participated in person except Director Shivers, who participated remotely under Just Cause, using her first of two under Just Cause as a result of AB 2449)

Members Absent: None

Chair Corwin noted for the record that there were no reportable actions taken in Closed Session.

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Supervisor Sarmiento thanked everyone for the warm welcome and preparation in advance of the meeting. He noted that he plans to learn from everyone and they will make his learning curve less steep.

Mr. Hunn again welcomed Supervisor Sarmiento to the Board. He also welcomed Supervisor Wagner as the alternate member on the CalOptima Health Board and noted that he looks forward to working with the new members and learning from them as well.

Supervisor Chaffee commented on the Board's approval of the actions related to the RFPs, noting that if CalOptima Health did not provide the dollar amount in the Board action, staff would still need to come back to Board.

Chair Corwin commented that he was thinking about that earlier as well when he said that there are pros and cons with the RFP process, not only in efficiency, but also in getting the results. Chair Corwin added that staff will look at the pros and cons and provide the Board with additional details so it can make an informed decision about what is the best procurement process for the organization going forward.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 4:47 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: April 6, 2023

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 17, 2022

A Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee (FAC) was held on November 17, 2022, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings

Chair Isabel Becerra called the meeting to order at 3:02 p.m., and Director Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Clayton Corwin; Scott Schoeffel (all members participated remotely)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Nancy Huang, Chief Financial Officer; Yunkyung, Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided updates on the Department of Health Care Services (DHCS) Calendar Year (CY) 2022 and 2023 rates release. Ms. Huang noted that DHCS will deliver the final CY 2022 rates to Medi-Cal managed care plans after March 31, 2023. She added that the delay was caused by the Centers for Medicare & Medicaid Services (CMS) requiring additional review of the Unsatisfactory Immigration Status (UIS)/Satisfactory Immigration Status (SIS) rate packages. The additional changes from the CY 2022 draft rates include various public health emergency (PHE rate impacts, including Long-Term Care category of service increases, risk adjustments, population acuity, pass-through payments, Managed Care Organization (MCO) tax. The finalization and delivery of the CY 2023 rates are expected in mid-December 2022.

Ms. Huang also reported that staff are working with outside actuaries to start the Medi-Cal rebasing process to implement at the beginning of the Fiscal Year 2023-24 budget to ensure sufficient funding for CalOptima Health's health network partners to provide appropriate member care. This will help to

ensure that actuarially sound capitation rates are developed by category of aid and staff will utilize data from multiple years to account and adjust for the effects of COVID-19 and post-pandemic care. CalOptima Health plans to share the preliminary results with its health networks in early 2023.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of July 1, 2022, through September 30, 2022. The portfolio totaled approximately $2.6 billion as of September 30, 2022. Of this amount, $2 billion was in CalOptima Health's operating account, and $564 million was included in CalOptima's Board-designated reserves. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

Director Corwin asked if CalOptima Health's overall portfolio performance was positive or negative.

Ms. Huang responded that as of Sept 30, 2022, CalOptima Health's quarterly return was positive (0.096%), but year-to-date (YTD) was negative (-0.916%).

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

3. Approve the Minutes of the September 15, 2022, Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the July 25, 2022 Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 4-0-0)***

REPORT

4. Recommend that the Board of Directors Approve Modifications to CalOptima Health Policy GA.3400: Annual Investments

Ms. Huang introduced the item noting that following the annual review process, Payden & Rygel and MetLife, CalOptima Health's investment managers, and Meketa Investment Group, Inc., CalOptima Health's investment adviser, submitted proposed revisions to CalOptima Health Policy GA.3400: Annual Investments for CY 2023. Staff has reviewed the proposed revisions and recommends approval of the following modifications. The first recommended change is to replace traditional money market with comparable fixed rate. The rationale behind this change is to clarify that floating rate securities should be comparable to fixed rate securities. The second recommended change is to add Code 40% to Commercial Paper and detailed footnote. Ms. Huang added there is no change to the actual current maximum percentage allowed in the commercial paper section it is still set at twenty-five.

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Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the CalOptima Health Board of Directors approve modifications to CalOptima Health Policy GA.3400: Annual Investments. (Motion carried 4-0-0)***

The following items were accepted as presented.

5. September 2022 Financial Summary

6. CalOptima Information Technology Services Security Update

7. Quarterly Operating and Capital Budget Update

8. Quarterly Reports to the Finance and Audit Committee
   a. Shared Risk Pool Performance
   b. Whole-Child Model Financial Report
   c. Enhanced Care Management Financial Report
   d. Reinsurance Report
   e. Health Network Financial Report
   f. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

There were no Committee member comments.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, wished everyone a Happy Thanksgiving and commented that he is thankful for all of the work that the Board puts in. He noted that it takes a lot of work to get things done right.

Chair Becerra thanked Dr. Pitts for his comments and noted that the holidays tend to sneak up on us and we forget that next week is Thanksgiving. Chair Becerra added that the FAC will not meet again until February and wished everyone happy holidays as well.

Hearing no further business, FAC Chair Becerra adjourned the meeting at 3:22 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 9, 2023

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

December 14, 2022

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee was held on December 14, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Chair Trieu Tran called the meeting to order at 3:01 p.m., and Sharon Dwiers, Clerk of the Board, led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.; Nancy Shivers, R.N. (at 3:04 p.m.) (all members participated via teleconference)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided a verbal update highlighting actions that the CalOptima Health Board of Directors approved at its December 1, 2022, meeting to improve outcomes for members in several areas, including cancer screening. Dr. Pitts also noted that CalOptima Health is working on a skilled nursing facility (SNF) incentive program to ensure members are treated at appropriate levels of care.

Dr. Pitts also reported that CalOptima Health received a monetary sanction notice from the Department of Health Care Services (DHCS) due to not meeting the required minimum performance levels (MPL) for calendar year 2021. He noted the two areas that did not meet the required MPLs were: well-child visits in the first 15 months and the well-child visits age 15 to 30 months. CalOptima Health will submit a revised comprehensive quality strategy to DHCS before January 31, 2023.

Director Mayorga commented that he is excited to see the cancer screening initiative and noted the importance of collaborating with CalOptima Health's radiological partners, hospitals, and health networks. Many providers have certain vendors they use for imaging services, which ultimately limits access. Director Mayorga asked if there is a way to make this an open network so that members would be able to get screened for lung, breast, and other cancers at multiple locations.

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Director Mayorga also inquired if CalOptima Health is aware of any other health plans that received a similar sanction. Yunkyung Kim, Chief Operating Officer, responded that most of the state's medical plans received a similar notice of varying ranges of performance in 2021.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

2. Approve the Minutes of the September 14, 2022 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

INFORMATION ITEMS

3. Blood Lead Screening Update

Leslie Martinez, QA Analyst, Population Health Management, provided an update on blood lead screening. Ms. Martinez noted that for CalOptima Health and Orange County, there are opportunities for improvement in screening children for lead in their blood. Overall, only 1% of children in Orange County have received a blood lead screening. She noted that no amount of lead in the body is safe, and for children lead in the body can affect the ability to pay attention and limit academic achievement, not allowing them to reach their maximum potential. Ms. Martinez also noted that lead in the body can damage the brain and nervous system and cause a lot of learning and behavioral problems, as well as hearing and speech problems. Most of the symptoms of lead exposure are not obvious, so blood lead testing is extremely important for younger children. She added that low-income children and children of color are disproportionately at risk for lead exposure, and these children are in publicly funded programs, such as CalOptima Health.

Ms. Martinez reported that CalOptima Health is trying to get a better understanding of where lead lies in the environment, which involves a lot of research. There are multiple case studies that have emerged that really pinpoint where lead is in the environment. She noted that researchers from University of California Irvine have reviewed samples from Santa Ana and they were able to identify and characterize 11 census tracts within this area as high risk for lead exposure. Many of the areas identified as having higher lead content in the environment are where a large number of CalOptima Health members reside. These areas are close to historic roadways, and research indicates that gasoline is a strong contributor.

As an organization, CalOptima Health is taking a multi-pronged approach that not only targets CalOptima Health's members, but also its providers through education and call campaigns. In addition, CalOptima Health supplies providers with a blood lead tool to help with documentation when blood lead tests are refused. CalOptima Health also provides quarterly reports to its health networks, which is basically a list of members who have not met the screening requirements in accordance with the California State mandate.

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The Committee members expressed an interest in knowing the trends on blood lead testing and results for various networks and sharing of strategies that are working well for the higher performing networks.

4. Population Health Management Strategy Update

Katie Balderas, Director, Population Health Management, presented an update on CalOptima Health's Population Health Management (PHM) Strategy. Ms. Balderas noted that CalOptima Health's PHM strategy builds upon the momentum of California Advancing and Innovating Medi-Cal (CalAIM) by focusing its efforts on upstream prevention and whole-person care. DHCS has provided guidance for this strategy that will require making changes to the way managed care plans deliver the PHM program starting January 1, 2023. This strategy also includes PHM Service, which is a technological service that supports DHCS's PHM vision by integrating data from disparate sources, performing population health functions, and allowing for multiparty data access and sharing. The PHM Service is scheduled to launch statewide in July 2023. Ms. Balderas reviewed the PHM program details and the timeline with Committee members.

5. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

Monica Macias, Director, PACE Program, provided an update on the recent activities of the PACE Member Advisory Committee (PMAC). Ms. Macias shared that the PMAC members are continuing to meet in person. She noted that the participants continue to provide great feedback in terms of how the program is doing. Ms. Macias also announced that CalOptima Health PACE has a new medical director, Dr. Donna Frisch, who brings a wealth of knowledge, and CalOptima is thrilled to have her on board.

Agenda Items 6.a. through 6.c. were accepted as presented.

6. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Committee Report
b. Program of All-Inclusive Care for the Elderly Report
c. Member Trend Report

COMMITTEE MEMBER COMMENTS

Director Mayorga thanked the staff for all their work and for always responding to his many questions quickly.

Director Shivers commented that she continues to be awed by the level of commitment and dedication of CalOptima Health staff in serving their members.

Chair Tran thanked Leslie Martinez, Katie Balderas, and Monica Macias for their informative presentations.

The Committee wished everyone a Happy Holiday and Happy New Year.

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ADJOURNMENT

Hearing no further business, Chair Tran adjourned the meeting at 3:51 p.m. The next Quality Assurance Committee meeting is scheduled for March 8, 2023.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 15, 2023

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Receive and File 2022 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation and Approval of the 2023 CalOptima Health Program of All Inclusive Care for the Elderly Quality Improvement Plan

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Donna Frisch, M.D., PACE Medical Director, (714) 468-1044
Monica Macias, LCSW, PACE Director, (714) 468-1077

Recommended Actions

- Receive and file the 2022 CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement (QI) Plan Evaluation, and
- Approve the 2023 PACE QI Plan.

Background

PACE is viewed as a natural extension of CalOptima Health's commitment to integration of acute and long-term care services for its members. This program provides the link between 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. As of December 31, 2022, CalOptima Health PACE has 434 active 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 and participant satisfaction.

PACE organizations are required to have a written 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 Health 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.

The 2022 PACE QI Plan Evaluation analyzes core clinical and service indicators to determine if the 2022 QI Plan has achieved its key performance goals for the year. In 2023, CalOptima Health PACE continues to expand participants services and update quality element goals and continued efforts to ensure comprehensive care. The 2023 PACE QI Plan reflects CalOptima Health's efforts to continue a high level of quality while also focusing on improving health outcomes and access for program participants.

Discussion

In 2022, the continued COVID-19 pandemic created challenges that significantly impacted CalOptima Health PACE. PACE faced these challenges head-on and continued to provide direct care to hundreds of

the county's frail and senior population who are most at risk of contracting the COVID-19 virus. As a quality element, PACE was able to assist 98% of participants in becoming vaccinated against COVID-19 with >95% of those eligible also receiving *at least one* COVID-19 booster dose. Despite COVID-19, the PACE program was still able to meet quality work plan goals while also maintaining overall participant satisfaction with services above the national level for PACE centers.

CalOptima Health PACE has updated the 2023 QI Work Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner. The 2023 PACE QI Plan, created through a collaboration of the PACE leadership members, refines the PACE quality elements based on the current population's health needs. The 2023 PACE QI Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2023 PACE proposes:

1. To add an element focused on the identification of osteoporosis in those who have had a fall, in order to reduce bone loss and lower risk of fracture through treatment.
2. To ensure that eligible participants receive their *bivalent* COVID-19 vaccine boosters to prevent infection and hospitalization.
3. To continue to strive for Medicare Quality Compass HEDIS 95th percentiles for diabetic care elements.
4. To assist in providing participants in completing advanced health care directives.
5. To focus on preventing falls with injury and repeated falls among participants.
6. To continue to provide excellent service to participants in areas of transportation, meals, and overall satisfaction with the PACE program.

Rationale for Recommendation

The Centers for Medicare and Medicaid requires PACE organizations to develop, implement, maintain, and evaluate an effective, data-driven QI program. As part of the QI program, the PACE organization must have a written QI Plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the QI Plan annually and revise it, if necessary.

Fiscal Impact

The recommended action to approve the 2023 PACE QI Plan has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2022-23 Operating Budget. Staff will include expenditures for the period of July 1, 2023, through December 31, 2023, in the FY 2023-24 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

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Attachments

1. 2022 CalOptima PACE QI Program Evaluation
2. Proposed 2023 PACE Quality Improvement Program and Work Plan (Redline version)
3. Proposed 2023 Quality Improvement Program and Work Plan (Clean version)
4. PowerPoint Presentation: 2022 PACE QI Work Plan Evaluation
5. PowerPoint Presentation: 2023 PACE QI Work Plan

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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CalOptima Health Program of All-Inclusive Care for the Elderly

2022

Quality Improvement Plan

Annual Evaluation

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SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

_____ _____

Dr. Donna Frisch , M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Acting Chairperson:

_____ _____

Clayton Corwin **Date**

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2022 CalOptima Health PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

As the COVID-19 pandemic continued into 2022, unprecedented challenges continue to impact all areas of life. CalOptima Health 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.

When the pandemic was first 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. We have continued to closely follow all updated mandates to provide a safe environment for our staff and participants.

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 continued public health emergency. This has 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 continued with our service delivery matrix to provide 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. Additional "PACE without Walls" services delivered by our transportation team included care packages containing items such as activity books, calendars, and games. Participants eagerly awaited these care packages and the opportunity to connect with others beyond their home.

Understanding the importance of continuing to provide preventive health services, we continued drive-through flu immunizations and as well as drive-through COVID-19 testing throughout 2022. A collaboration between the PACE clinic, the Quality Improvement department and the PACE scheduling team led to increased COVID vaccination numbers. We were able to end 2022 with a 98% participant COVID-19 vaccination rate. Additionally, efforts were made throughout the year to provide participants with the latest recommended booster doses, whereby >95% of eligible PACE participants received *at least* one COVID-19 booster dose.

Understanding the profound importance of maintaining contact with our PACE participants through the ongoing pandemic, we continued with our previously implemented "wellness calls" to check in on the well-being of our participants. As of the end of 2022, close to 66,000 wellness calls have kept participants connected with PACE since the start of the COVID-19 pandemic.

Following state and local guidelines, PACE Day center attendance slowly increased throughout 2022. All CDC guidelines were put into place to ensure safety protocols are being followed. Participants remain grouped into "pods" where they join with a small number of other participants to promote social distancing, with two staff members assigned per pod. Participants are chosen for day center attendance by IDT based on who needed the most support and who were able to follow the CDC guidelines (i.e., wear a mask, stay 6 feet apart). Any participants attending day center services must also be fully vaccinated against COVID-19 with both initial doses, as well as a booster dose. Additionally, despite several COVID-19 surges, we were able to provide more face-to face services for participants with their providers, clinic, and rehabilitation staff. We have

worked diligently to provide as many in-person services to our participants as possible, while also assessing risk factors for spread of disease and implementing processes to mitigate these risks. In July of 2022 we implemented the requirement for all staff and participants to wear KN-95 level masks while in the PACE building, to further expand our efforts against disease transmission.

Despite the continuing challenges of COVID-19 we continued to enroll new participants and saw our highest enrollment numbers by the close of 2022. When CalOptima Health PACE first opened for operations on October 1, 2013 we had 13 participants. We have seen continued growth in enrollment through the years and at the end of 2022, we had 434 participants enrolled. The multi-cultural background and the diversity of our participant population provides a very vibrant and engaging environment at PACE. Out of our 434 participants, the primary languages are 63% Spanish, 16% Vietnamese, and 14% English and other languages spoken include Arabic, Tagalog, Chinese, Urdu, Hindu, Persian and Telugu. CalOptima Health PACE ensures that participants are always provided with opportunities to communicate in their preferred language using professional interpreter services and that PACE staff provide culturally competent care to each of our members.

The purpose of the CalOptima Health 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 Health PACE.

The goal of the CalOptima Health 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 2022 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2023 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). It is then reviewed and approved by the CalOptima Health Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Health Board of Directors annually. The 2022 PACE QI Plan was reviewed and approved by the CalOptima Health Board of Directors on April 7th 2022.

The CalOptima Health 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 the PACE QI Plan is provided by the CalOptima Health Board of Directors.

The CalOptima Health PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima Health'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 2022, CalOptima Health PACE's accomplishments include:

1. Swift response to updates regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
2. Use of telehealth modalities that enabled participants to "visit" their providers from their homes.
3. Connected with participants through 6,381 wellness calls, 40,591 home delivered meals and provision of 1405 wellness care packages throughout 2022.
4. Provided infection control training to all staff in accordance with CDC, DHCS and CDPH directives.
5. Oversight of PACE contractors to ensure compliance to state and federal COVID-19 vaccination guidelines.
6. Implemented robust staff COVID-19 safety compliance, including decision to require staff to wear KN95 face masks when in the PACE facility and to maintain social distancing with other staff.
7. Implemented robust participant COVID-19 booster vaccination initiative, with 95% of eligible participants having received *at least one* booster dose by the end of 2022.
8. Implemented a plan to assist eligible participants with receiving the bivalent COVID-19 booster which became available in September 2022.
9. Implemented a plan to increase PACE Day center activities and attendance in accordance with infection control guidelines.
10. Continued COVID-19 visitor vaccination protocols, which included proof of vaccination for those accessing the PACE Center and rapid antigen testing for unvaccinated caregivers who accompany participants for PACE services
11. Weekly COVID-19 updates to the leadership team and monthly updates during our all-staff meetings.
12. 93% of participants received their annual influenza vaccine.
13. 88% of participants completed their Pneumococcal vaccine series.
14. Continued enhanced care coordination program for participants on dialysis.
15. 100% of participants had their medications reconciled within 15 days of hospital discharge.
16. Prompt review by clinical pharmacist of specialty medications ordered by outside specialists.
17. Retrospective reviews of medication utilization were performed daily and monthly. Recommendations were immediately addressed with the PACE provider and/or IDT.
18. Quality of Diabetes Care
    a. 96% of participants with diabetes completed an annual eye exam.
    b. 100% of participants with diabetes had nephropathy monitoring.
19. Utilization:
    a. Only 3.8% participants were placed in long-term care in 2022.
    b. Continued the PACE Emergency Room (ER) Diversion program.
    c. Continued to provide in-house specialist care including podiatry, psychiatry, nephrology and dental services for improved access and coordination of care.

d. Morning clinical huddles continue to be incorporated into the IDT meetings for all teams.

20. Transportation:
    a. On-time performance of 98%.
21. Participant Satisfaction
    a. 89% overall satisfaction with care received compared to the national average of 88.6%.
    b. 84% satisfaction with Recreational Therapy compared to national average of 79.1%
    c. 82% satisfaction with Meals compared to national average of 71.1%
22. 100% of staff competency assessments were completed. Year-round staff trainings were provided covering a broad area of topics included infection control, emergency responses, grievances, appeals, service delivery requests, and participant rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

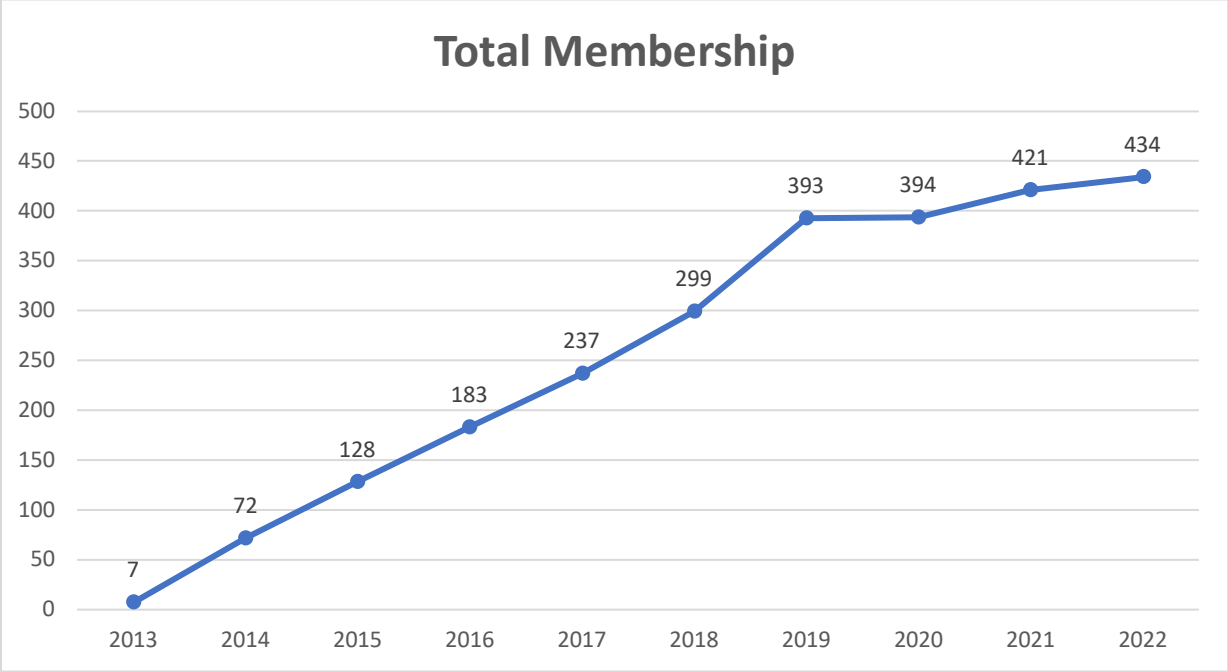
1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing 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, especially as it pertains to the unique needs of the population. 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 by medical case manager.
    f. The ongoing infection control activities, specifically tracking, reporting, and treatment of all infectious disease cases.
    g. Collaboration with the CalOptima Health Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
    h. The annual approval of up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
    i. The PACE Clinic Workflow to efficiently address participant care issues during the COVID-19 pandemic.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners. Accomplished and evidenced by:
    a. The Interdisciplinary Care Team (IDT) meetings at CalOptima Health PACE.

    b. Continued presence of physicians and nurse practitioners during IDT meetings.
    c. Addition of preferred specialists who regularly provide services within the PACE clinic.
    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. Accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. Podiatry, nephrology, dental and psychiatry staff providing on-site care.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service. Accomplished and evidenced by:
    a. The credentialing and peer review process.
    b. Annual evaluations of all CalOptima Health PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances. Accomplished and evidenced by:
    a. The 2022 PACE Participant Satisfaction Survey showing that PACE member satisfaction is higher than national average.
    b. The summary of grievance and appeals activities.
    c. The ongoing input from the PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes. Accomplished and evidenced by:
    a. The QI activities which occur around all Unusual Incidents and including root cause analyses and recommendation for improvement and follow up.
    b. Physical therapy driven groups designed to prevent falls.
8. Compliance with regulatory agencies and accreditation standards. Accomplished and evidenced by:
    a. The successful submission of data as required by CMS and DHCS each quarter.
9. Compliance with clinical practice guidelines and evidence-based medicine. Accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The use of Uptodate.com clinical practice standards.
    c. On-going PACE staff training.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently. 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 leadership team meetings.
    e. The participation in the CalOptima Health QI, UM, and Credentialing and Peer Review Committee meetings.
    f. The participation in the CalOptima Health Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima Health 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, nine years later, we have 434 active participants.



As illustrated in the membership graph, PACE has seen a steady enrollment trend over the years. Due to the COVID-19 pandemic, there was almost no growth noted in 2020. However, despite continued challenges, in 2021 and 2022 PACE once again saw an upward trend in enrollment numbers.

In 2023, our goals for program growth remain intact and strategies are already being put into place to accommodate participants post-pandemic. We continue our aggressive marketing strategies which includes print, radio and television media to reach a wider audience throughout Orange County.

2022 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI22.01 PACE QAPI Plan and Work Plan will be evaluated annually

Approved by the CalOptima Health Board of Directors on April 7, 2022.

QI22.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Health Board of Directors on April 7, 2022.

QI22.03 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, 2022.

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 only one percentage point, an improvement from 2021's end of year performance of 91%. Vaccines were pre-ordered in late spring from our distributer, and we began to vaccinate participants when vaccines arrived in August 2022. PACE used strategies to reach all eligible participants, such as an aggressive flu vaccination campaign which included vaccine clinic events at PACE. 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 CalOptima Health PACE reported zero influenza outbreaks among our participants or staff in 2022. Our influenza vaccination efforts for the 2022/2023 flu season will extend through Quarter 1 of 2023 where we will continue to reach out to the unvaccinated.

QI22.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their PCV23 pneumococcal vaccination by December 31, 2022.

Goal: Not Met

Data/Analysis: 88% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2022, 88% of our participants had completed pneumococcal vaccination, not meeting our goal for 2022. The PACE QI department provided detailed reports to the clinic 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 2022, a new vaccine was introduced to PACE- Pneumococcal 20, which is a one dose vaccine that eliminates the timing and dosage challenges of the previously approved pneumococcal series. In 2023, we anticipate that the identification of those needing vaccine through review in the California Immunization Registry (CAIR2) in addition to the new one dose vaccine will increase our ability to meet and maintain the 94% goal moving forward.

QI22.05 Increase COVID-19 immunization rates for all eligible PACE participants

Goal: Greater than or equal to 95% of eligible participants will have their COVID-19 vaccination by December 31, 2022.

Goal: **Met**

Data/Analysis: 98% of participant received COVID-19 vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2022, 98% of PACE participants had received either 1 dose of Janssen or 2 doses of Moderna or Pfizer COVID-19 vaccine. Additionally, we were able to further our efforts by assisting with the process of getting participants their recommended booster doses as well, discussed in the quality initiative section. In 2023, we plan to continue our efforts to ensure that all PACE participants are fully vaccinated against COVID-19 by changing this quality element goal to "80% will be vaccinated with the *Bivalen*t COVID-19 vaccine" which is the latest recommended vaccine by the Centers For Disease Control.

QI22.06 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, 2022.

Goal: Not Met

Data/Analysis: 94% of participants enrolled in the PACE program for 6 months had POLST by the end of 2021.

Quarters 2022	Completion Rate
Q1	90%
Q2	92%
Q3	96%
Q4	94%
EOY	**94%**

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal in 2022, being only 1% below our target goal. However, through the efforts of our Primary Care Providers and the Associate Clinical Medical Director we were able to improve on our 2021 end of year performance of 91%. End-of-life decisions are reviewed with the participant by the Provider to complete this important document that respects the wishes of each participant. 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.

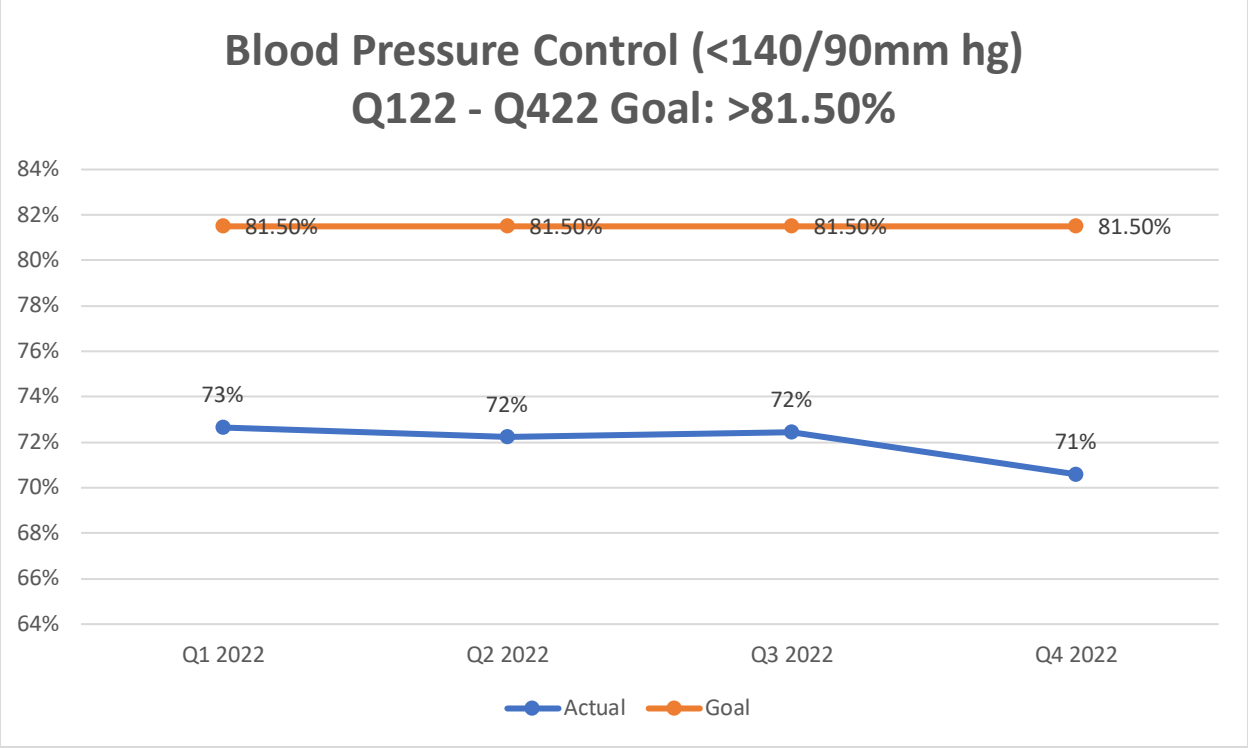
In 2023, we plan to continue our efforts to ensure that our participants have a POLST in place. In addition to the PACE Clinical Operations Manager having oversight of this element, the PACE Medical Director will also be assisting with plans to reach our goal in 2023.

QI22.07 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: Not Met

Data/Analysis: The 2022 final average was 72%.



Diabetics with Controlled Blood Pressure					
	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	**75th Percentile**	90th Percentile	95th Percentile
72%	58.64%	65.69%	**72.02%**	77.86%	81.51%

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal in 2022. Some reasons for this may have been that the pandemic limited face to face appointments and closer intervention of BP management, fewer participants were in the day center getting healthy meals and home diets may have been less optimal due to inflated cost of healthy foods. For 2023 we will be taking measured steps to meeting the HEDIS 95th percentile by implementing the following:

- We will identify participants with the diagnosis of frailty on the care plan and those patients will be excluded.
- If BP high on first reading MA will repeat prior to participant leaving. If still high participant will have follow with RN to check home readings and if still high provider will review and adjust medications and offer dietician.
- We are increasing the day center participation so that we can directly monitor diet and blood pressure in our participants.
- We will be giving out more home BP monitors.
- We are doing more face-to-face appointments in all departments.

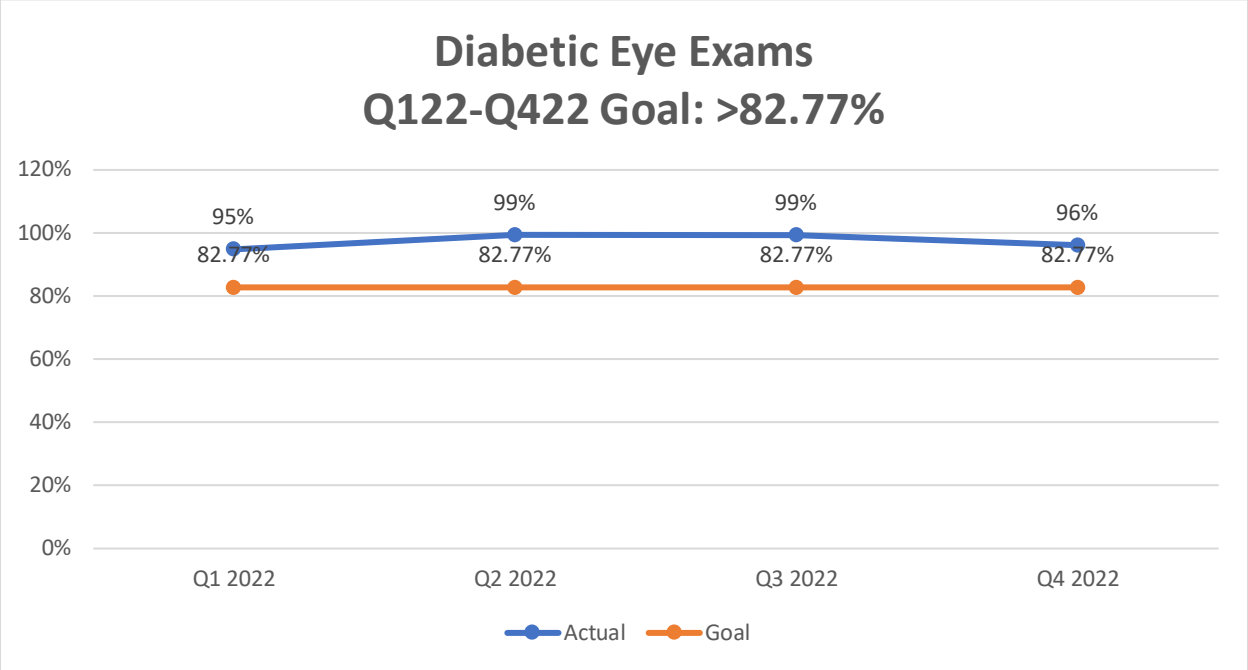
This goal will be updated to 84.21% for 2023 to reflect changes in HEDIS goals for 2023. (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan)

QI22.08 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 82.77% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2022 final rate was 96%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
96%	62.56%	69.34%	76.3%	80.78%	**82.77%**

Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 96% of diabetic participants having received an annual eye exam in 2022. With the assistance of monthly reports generated by the PACE QI team, 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. Contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are above the 2020 Medicare HEDIS Quality Compass 95% percentile. In 2023, the goal will be changed to >85.42% of Diabetics will have an Annual Eye Exam (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan). We anticipate no difficulty in once again exceeding this goal in 2023.

QI22.09 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 2022 final rate was 100%.

Comprehensive Diabetes Care: Medical Attention for Nephropathy

	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
100%	92.46%	94.74%	96.11%	97.81%	**98.3%**

Summary Key Findings/Opportunities for Improvement: In 2022, 100% of our diabetic participants received nephropathy monitoring, matching our success from 2021. 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 2020 Medicare HEDIS Quality Compass 95th percentile. PACE will increase this goal to 98.78% to reflect the changes to the HEDIS Quality Compass 95th percentile. (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan). We anticipate no difficulty in once again exceeding this goal in 2023.

QI22.10 Ensure participants with Osteoporosis are receiving treatment

Goal: Greater than or equal to 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP

Goal: Met

Data/Analysis: The 2022 final rate was 98%.

Quarter 2022	Rate
Q1	97%
Q2	98%
Q3	99%
Q4	98%
EOY	**98%**

Summary Key Findings/Opportunities for Improvement: In 2022, 98% of our participants with Osteoporosis were actively receiving treatment including medications such as bisphosphonates with a goal to stop bone loss and improve bone density. PACE providers have been diligent in the treatment of this disease which can lead to disfunction and increased fractures in the elderly. Moving into 2023, we will be focusing on ensuring that all participants who sustain a fall will have been identified for Osteoporosis and bone fracture risk using Dual-energy X-ray absorptiometry (DEXA) scans.

QI22.11 Decrease the number of falls classified as CMS reportable quality incidents

Goal: <207 Falls per 1000 member months falls that resulted in fracture, hospitalization, or death.

Goal: Met

Data/Analysis:

The 2022 rate was 59 falls per 1000 member months:

Quarter 2022	# Falls Per 1000 Per Year

Q1	49.00
Q2	53.00
Q3	54.00
Q4	59.00
EOY	**59.00**

Summary Key Findings/Opportunities for Improvement:

We met our goal for falls with serious injury in 2022. We have developed multiple strategies for prevention of recurring falls. After each fall, the rehabilitation team of licensed physical and occupational therapists determines if fall is mechanical or related to any medical problems of participant. The primary care provider and nursing team will check on medical factors and provide referrals and other interventions, as necessary. Pharmacy and provider work together to check medications if need to be adjusted for cases that concerns loss of balance, dizziness, or muscle weakness. Rehabilitation, homecare coordinator, and social provide interventions for mechanical falls such as tripping and or any changes in participant's environment and living situation. All other disciplines provide their inputs and interventions as the need arises. In 2023 we will continue our increased surveillance of repeat faller by instituting mandatory home assessments and follow up completed by PACE to reduce total number of falls at home.

QI22.12 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <27.24%

Goal: Met

Data/Analysis: The 2022 rate was 19%

DDE: Dementia + Tricyclic Antidepressant or Anticholinergic Agents					
	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
19%	43.4 %	37.36%	32.58%	27.24%	**24.03%**

Summary and Key Findings/Opportunities for Improvement:

In 2022, only 19% 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 Medicare HEDIS Quality Compass 95th percentile. Based on 2022 updates to HEDIS guidelines, we will be changing our goal from <24.03% to <24.64%

(Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan) and feel confident that we will once again exceed this goal.

QI22.13 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.47%

Goal: Met

Data/Analysis: The 2022 rate was 2.0%.

DDE: CKD+ Nonaspirin NSAIDS or Cox2 Selective NSAIDs					
	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
2%	13.31 %	9.24%	6.25%	3.47%	**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 2020 Medicare HEDIS Quality Compass 95th percentile. Based on 2022 updates to HEDIS guidelines, we will be changing our goal from <3.47% to <2.62% Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan) and feel confident that we will once again exceed this goal.

QI22.14 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 90mg

Goal: 100% of participants receiving opioids for 15 or more days at an average MME 90mg will be reevaluated monthly by their treating provider.

Goal: Met

Data/Analysis: The 2022 rate was 100%

Quarters 2022	# Participants on high dose opioids with PCP follow up
Q1	1 out of 1 participant reevaluated (100%)
Q2	1 out of 1 participant reevaluated (100%)
Q3	1 out of 1 participant reevaluated (100%)

Q4	1 out of 1 participant reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

In the 2022 we were able to fully meet our goal of 100% for each quarter. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing. The PACE QI department works in concert with pharmacy to identify any participants who may be taking high dosage opioids. These specific participants are then automatically added onto the provider's monthly schedule so that appropriate participant/PCP follow-up can occur. We will continue to track and monitor this in 2023 and anticipate that we will again achieve 100% in 2023.

QI22.15 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 15 days of hospital discharge in 2022

Goal: Met

Data/Analysis: 99% of participants had medications reconciled within 15 days post discharge in 2022.

Quarters 2022	# Participants with Medication Reconciliation within 14 days of discharge
Q1	100%
Q2	100%
Q3	100%
Q4	96%

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. Our clinic staff maintain a close relationship with our participants and 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 plays a vital part in the reconciliation process as well as a dedicated additional clinical staff members who handle medication reconciliation for hospital and SNF discharges. In 2023, we plan to change the goal of Post-Discharge Medication Reconciliation from within 15 days after discharge to within 10 days after discharge from hospital or SNF to home, to better ensure that our participants post-discharge needs are met in a timely manner to help prevent recurrent hospital admissions.

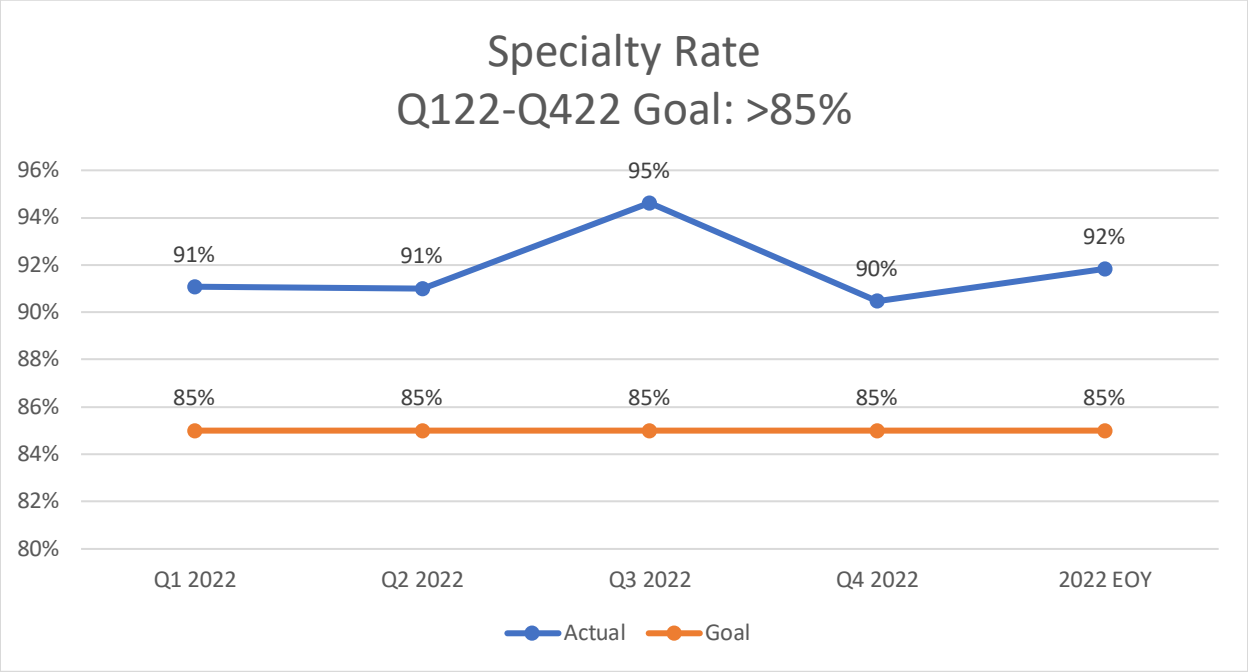
Access and Availability

QI21.17 Improve access to specialty practitioners

Goal: ≥ 85% of specialty care authorizations will be scheduled within 14 business days in 2022

Goal: Met

Data/Analysis: The 2022 rate was 92%.



Summary and Key Findings/Opportunities for Improvement:

Our PACE scheduling department continues to utilize strategies put in place to improve access to specialty care. In the past, we expanded the number of staff dedicated to scheduling specialty appointments. Specialty scheduling 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 continue to have a scheduler who is assigned to each of our IDT teams and focuses on coordinating all these activities.

We continued to provide dentistry services on-site as well as a nurse practitioner dedicated to primary care podiatry issues in 2022. We also utilized on-site psychiatry services and nephrology services. Throughout 2022, we have been able to increase some of those in house specialist activities, following strict COVID protocols. As part of our operational Work Plan for 2023, we will look to identify additional core specialists, such as ophthalmology, 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. In 2023 we are maintaining our benchmark goal that ≥ 85% of specialty care authorizations will be scheduled within 14 business days.

QI22.17 Improve access to telehealth

Goal: ≥ 66% of participants will have access to telehealth.

Goal: Not Met

Data/Analysis: 54% of participants had noted access to telehealth modalities by the end of 2022.

Summary/Key Findings/Opportunities for Improvement

PACE did not meet the benchmark of ≥ 65% of participants having access to engage in telehealth visits. Telehealth access is measured by the percentage of participants who are able install and correctly use the telehealth platform VSEE or other video conferencing applications. There are several challenges to providing video telehealth visits for our specific participant population, including a lack of accessibility to participants who may not have smart devices, bandwidth, or the physical/cognitive capability of using these types of applications. In 2022, despite the continued pandemic, participants were being seen in person at the center again, and so the need for video conferencing lessened. It is PACE's preference to perform in-person assessments and hands-on care within our PACE clinic and center. Due to the many complexities involved, in 2023 we will remove this element while continuing to operationally strategize on how to provide telehealth access to more of our members moving forward.

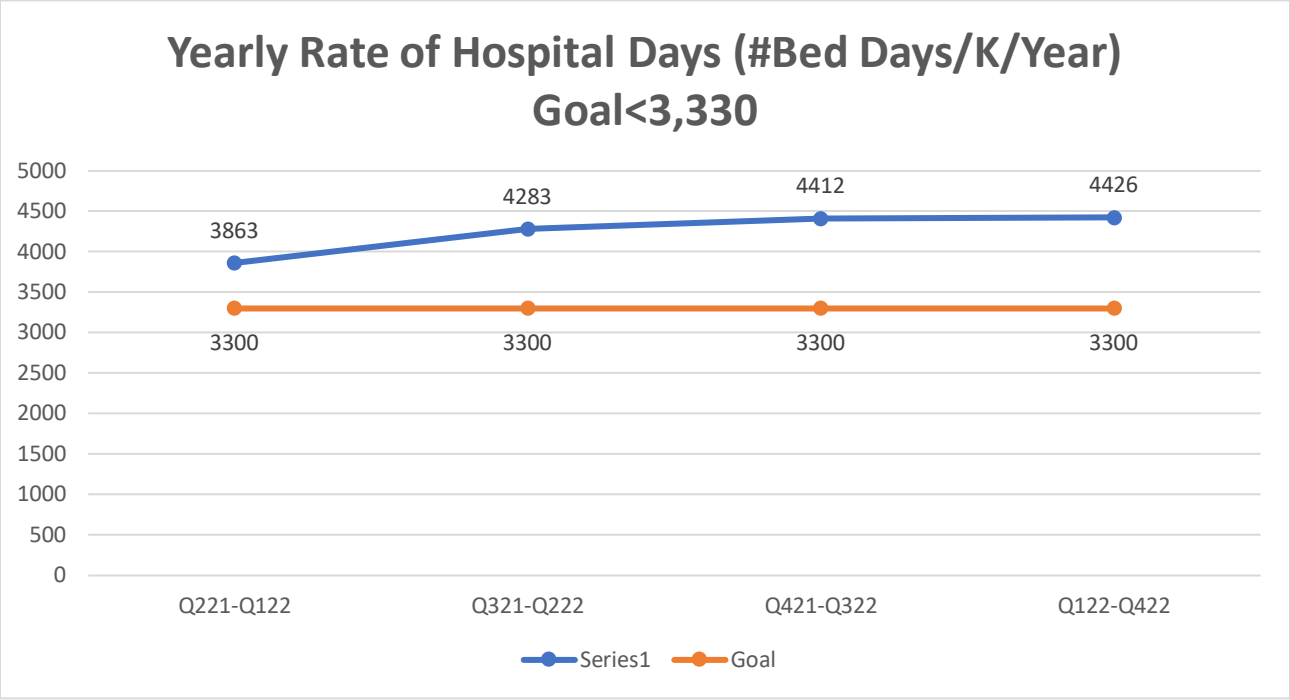
Utilization Management

QI22.18 Reduce the rate of acute hospital days by PACE participants

Goal: < 3,330 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2022 rate was 4,426 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

CalOptima Health PACE did not meet our goal of <3,300 hospital days per 1000 per year in 2022. The main reason for this is the high number of medically complex patients that are part of our program, including participants who required extended stays in Long Term Acute Care Hospitals

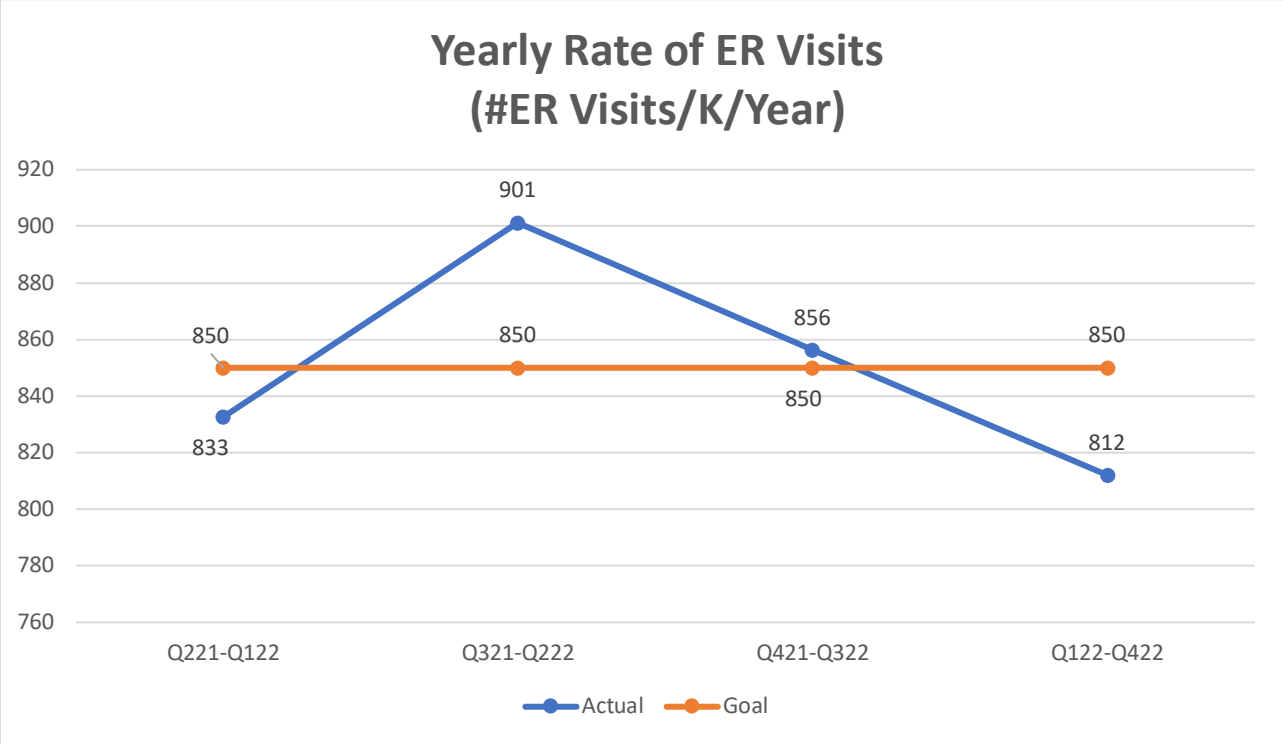
due to medical need, which contribute to overall hospital bed days. Despite the high level of care needs of our participants, PACE will continue to strive for this same goal in 2023. PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education.

QI22.19 Reduce the rate of ER utilization by PACE participants

Goal: < 810 emergency room visits per 1000 per year

Goal: Met

Data/Analysis: The 2022 rate was 810 emergency room only visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

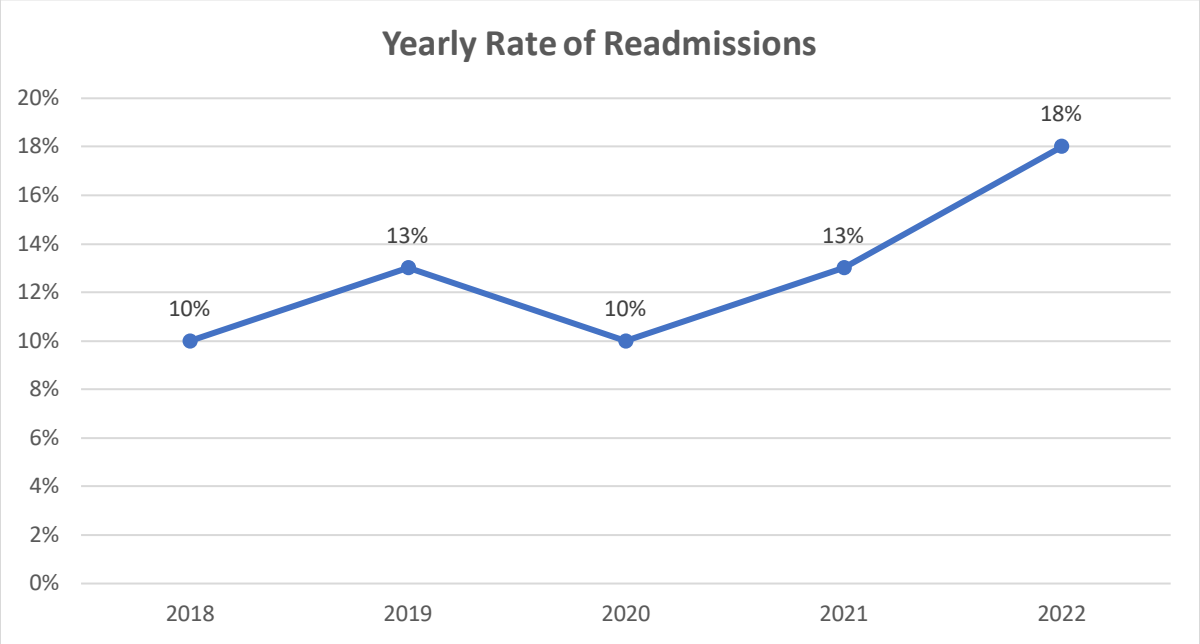
Emergency rooms visits increased throughout Q2 of 2022, but then steadily dropped in Q3 and Q4, allowing us to meet out final goal for 2022. Similar to our hospital utilization rates, we will be maintaining our goal of < 810 emergency room visits per 1000 per year in 2023. ER utilization by PACE participants 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.

QI22.20 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 14% 30-day all cause readmissions

Goal: Not Met

Data/Analysis: The 2022 rate was 18%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year to year due to the small total number of participants and readmissions. We ended 2022 with an 18% 30-day readmission rate which is a 3% increase from 2021. 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 2022, we continued to incorporate the morning clinical huddles into the interdisciplinary team meetings (IDT). Additionally, 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 reassess the participants immediate health needs following hospitalization as well as any long-term need for changes in care plan to prevent future hospitalizations. For 2023, we strive to reach lower readmission rates and will maintain our goal of a <14% readmission rate.

QI22.21 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 4% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: 2022 rate was 3.4% of the PACE enrollment resided in long-term care.

Summary and Key Findings/Opportunities for Improvement:

One of the most important tenets of the PACE program is to help our participants continue to live safely at home for as long as possible. We ended 2022 with 3.4 % of our participants residing in LTC, meeting our intended goal. There are several issues which contribute to a 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 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. In 2023, we plan to maintain our benchmark and investigate solutions to address the individualized care needs of our unique population.

Enrollment

QI22.22 Increase the Qualified Lead to Enrollment conversion rate

Goal: Increase the Qualified Lead to Enrollment conversion rate to 60%

Goal: Met

Data/Analysis: Final rate was 76%.

Quarter 2022	Rate
Q1	79%
Q2	74%
Q3	73%
Q4	76%
EOY	**76%**

Summary and Key Findings/Opportunities for Improvement:

In 2022, 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. Our screening, intake, and assessment tools to screen-out enrollees including those 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.

In 2023 we will continue to review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies improve on our conversion rates. In 2023 we will increase our conversion rate goal from 60% to 65%.

Transportation

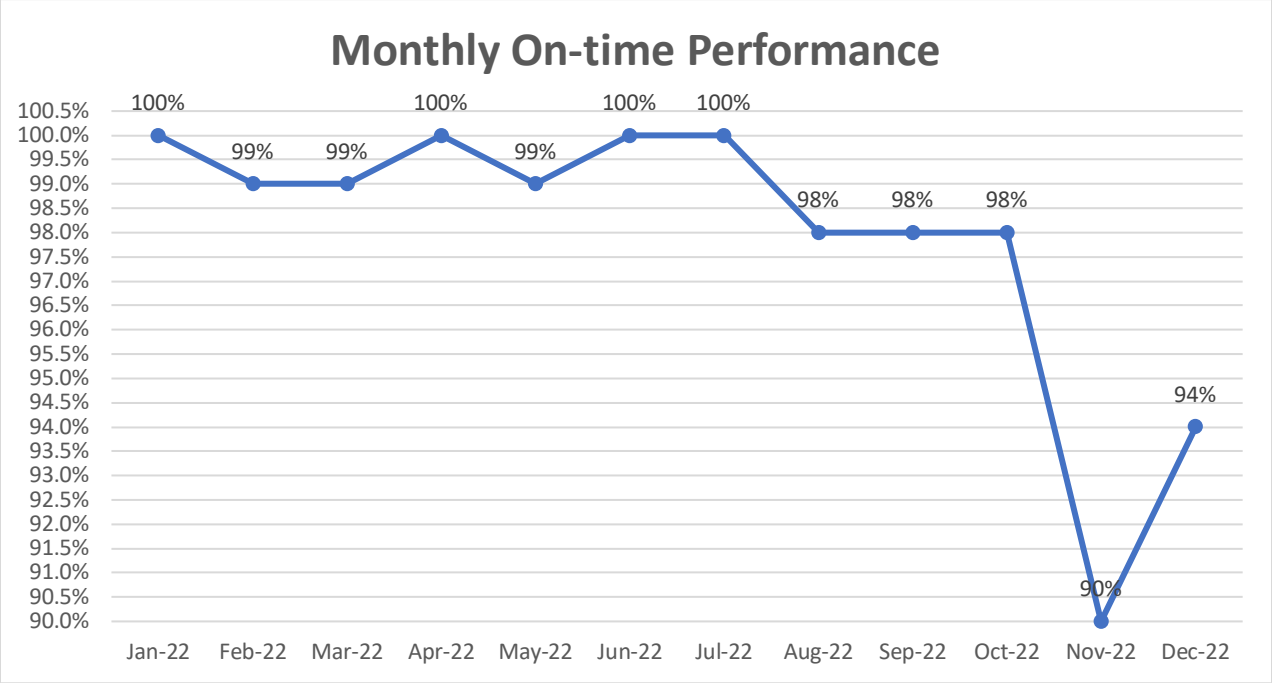
QI22.23 and QI22.24: Transportation Performance

Goal QI22.23: 100% of transportation trips will be less than 60 minutes in 2022

Goal: Met

Goal QI22.24: ≥92% of all transportation rides will be on-time in 2022

Goal: Met



Summary and Key Findings/Opportunities for Improvement:

2022 was a transitional time for the transportation department. Due to the ongoing pandemic, the transportation department continued to be utilized for drive-through immunization and COVID-19 testing, as well as delivery of care packages and durable medical equipment. Additionally, through 2022, PACE continued to slowly increase day center attendance. Despite increased demands and ever-changing protocols, transportation has continued to meet their performance benchmark. For the year, transportation completed 2022 with an on-time performance of 98%. In 2023 we will continue to actively monitor trends in transportation, not just in terms of timely performance, but also for participant satisfaction with services.

QI22.25: Transportation Satisfaction

Goal: ≥92% on the Overall Satisfaction with Transportation Services summary score on the 2022 PACE Satisfaction Survey

Goal: Not Met

Data/Analysis: 2022 rate was 89% Overall Satisfaction with Transportation.

Summary and Key Findings/Opportunities for Improvement:

Unfortunately, we fell short of our Transportation Satisfaction Goal in 2022. Despite this, 88% of participants surveyed stated that van service was *Good* to ***Excellent***. We take participant satisfaction with services very seriously and always strive to maintain the highest level of satisfaction. In 2023 we will raise our goal to ≥93.6% to compare with 2022 national averages. Our 2023 Quality Workplan also includes a Quality Initiative to address participant concerns with transportation in an effort to raise satisfaction and reduce grievances.

Meals

QI21.26 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 71% on Satisfaction with Meals summary score on the 2022 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 82% overall weighted participant satisfaction summary score on the 2022 Participant Survey Satisfaction with Meals Domains.

Domain	2021	2022	2022 National Average
Do the lunches taste good?	75%	76%	61.8%
Do you get a variety of foods here?	80%	89%	82.1%
Meal satisfaction composite score	80%	**82%**	71.1%

Summary and Key Findings/Opportunities for Improvement:

In 2022, we met our benchmark with 82% of PACE participants indicating satisfaction with their meals, far exceeding the PACE national average of 71.1%. In 2022, we once again 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 most participants are satisfied with meals provided by PACE. In 2022 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.

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 2023.

Participant Satisfaction

QI22.27 Improve the overall satisfaction of participants and their families with the CalOptima Health PACE program

Goal: Greater than or equal to 88% on the Overall Satisfaction Weighted Average on the 2022 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 89% overall weighted participant satisfaction summary score.

2022 Participant Survey Domains

Domain	2021	2022	2022 National Averages
Transportation	96%	89%	93.6%
Center Aids	95%	96%	91.7%
Home Care	90%	85%	85.8%
Medical Care	93%	87%	89.7%
Health Care Specialist	88%	85%	89.0%
Social Worker	97%	95%	94.5%
Meals	80%	82%	71.1%
Rehabilitation Therapy and Exercise	91%	93%	93.0%
Recreational Therapy	81%	84%	79.1%
General Service Delivery	92%	92%	86.4%
Weighted Summary Score	91%	**89%**	88.6%

Summary and Key Findings/Opportunities for Improvement:

In Fall 2022, CalOptima Health PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 101 of our 434 participants via telephone, to gauge the participant's satisfaction with CalOptima Health PACE services. This is a standardized survey completed by most of the PACE programs in the country.

The overall satisfaction score was 89%. Despite numerous challenges faced by CalOptima Health PACE including the continued need for pandemic related adaptations to service, as well as unprecedented levels of staffing turnover as part of the nationwide "Great Resignation" we were still able to excel in several areas of satisfaction in 2022.

We saw an increase in satisfaction scores from 2021 in areas such as Center Aids, Rehabilitation Therapy and Exercise, Meals and Recreational Therapy. We remained at our above national averages in areas such as Social Worker Satisfaction and General Service Delivery.
Our weighted summary score was 89%, slightly above the national average for overall participant satisfaction. In 2023 we hope to have our PACE day center reach full capacity again, reduce transportation related grievances, and maintain the highest possible level of service satisfaction in all domains.

SECTION 5: 2022 HEALTH PLAN MANAGEMENT SYSTEM (HPMS)

2022 HPMS: 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

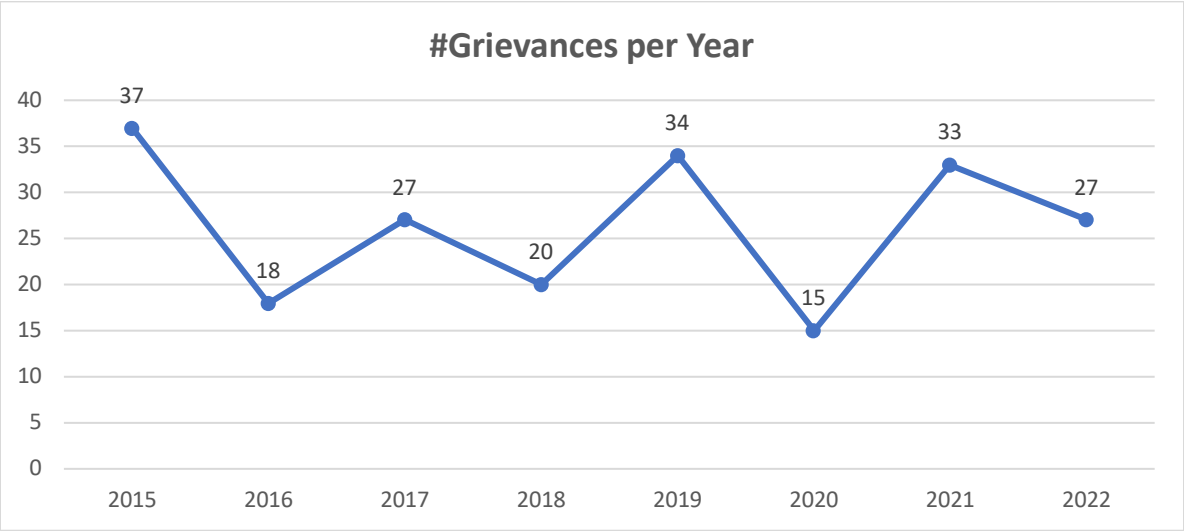
Grievances

Data Analysis:

Quarterly Grievances Q1 2022–Q4 2022

	CENTER							CLINIC			
					Transportation			Clinical Care/Service/ Treatment			
	# Grievances	Other	Food	Home Care	Timeliness	Prt-Driver Interaction	Quality of service	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q1 2022	4	0	0	0	3	0	0	0	1	0	0
Q2 2022	8	0	0	0	3	0	2	0	1	2	0
Q3 2022	7	0	0	0	4	1	0	0	0	2	0
Q4 2022	8	0	0	0	1	1	1	2	1	2	0

Grievances Per Year 2015–2022



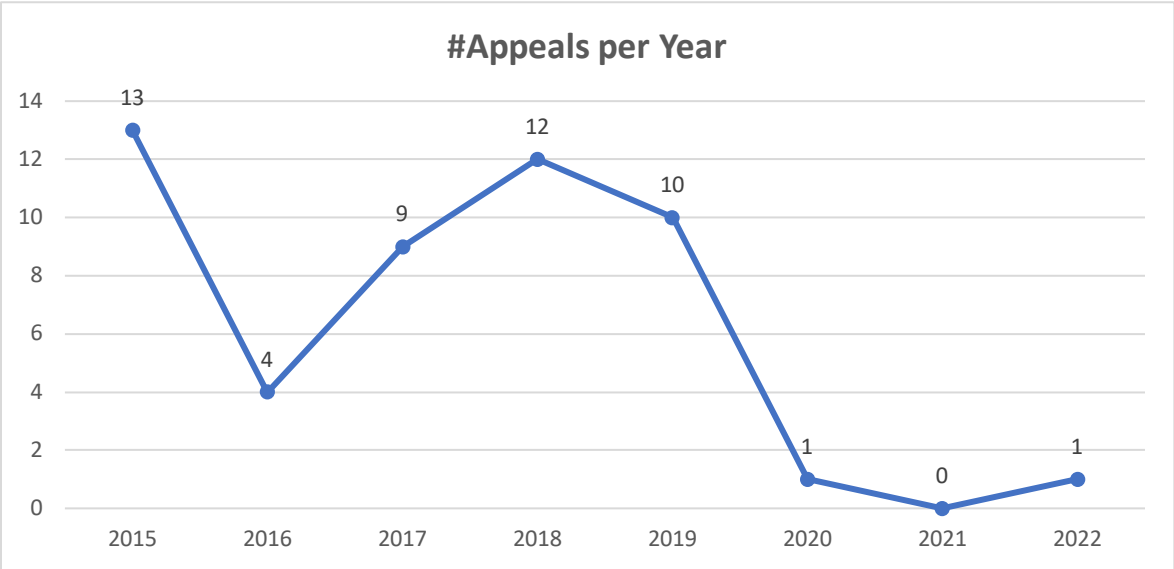
In 2022, we saw a decrease in the number of grievances filed by participants. Many of the grievances that were filed were transportation related issues such as being picked up late. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period. To fully resolved all transportation related grievances, in early 2022 we began sharing all grievances directly with our contracted transportation provider, Secure Transportation, and their Quality Assurance department. The Secure QA department thoroughly researchers each grievance and provides us with their investigation and resolution notes. Additionally, grievance issues are discussed during our monthly scheduled Secure Transportation meeting with the transportation leadership team. Corrective action plans are used as needed.

Most participants filing grievances are satisfied with the resolutions reached by the PACE QI department. As with previous years, we will continue to monitor and observe for trends with grievances filed.

Appeals

Data Analysis:

Appeals Per Year 2015–2022

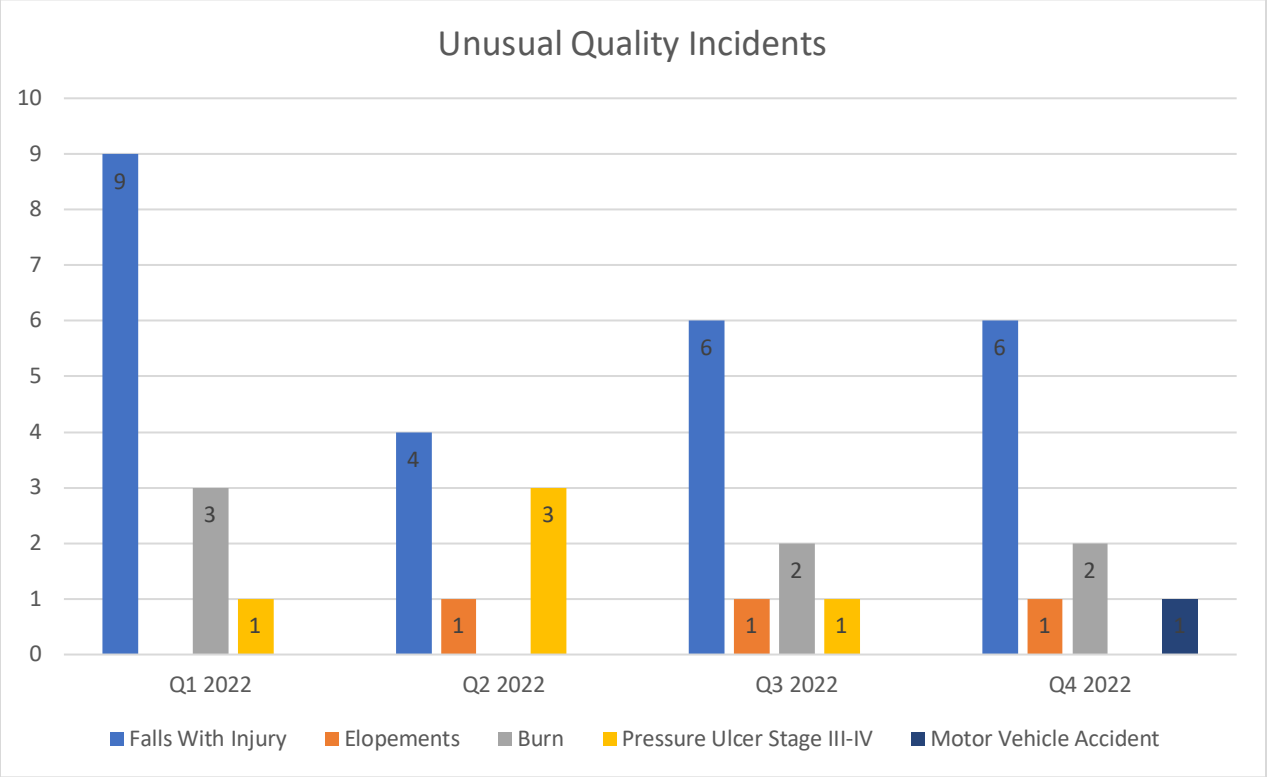


Appeals by participants continued to be minimal in 2022. Only 1 appeal was submitted in 2022 and a third-party review team upheld CalOptima PACE's IDT's decision. This reduction in appeals over the past several years in due in part to the time the IDT takes in explaining the reasons for denials to our participants and ensuring all their questions are answered and other resources are provided as necessary.

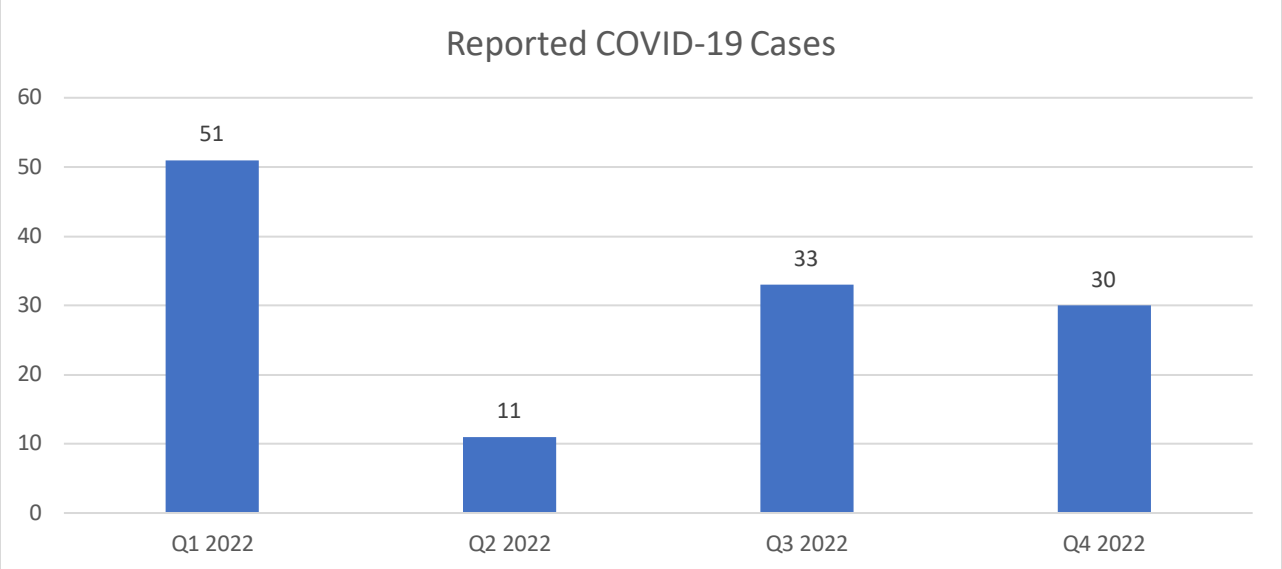
Unusual Quality Incidents

Description of Reportable Incidents: 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, unstageable), motor vehicle accidents 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) then followed by a meeting of appropriate disciplines such as nursing, social worker, and rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented. In 2022, there was two quality incidents that required corrective action. One was related to elopement, and one was related to a minor motor vehicle accident. Neither incident resulted in serious injury to the participant.

Data Analysis: See graph below



Falls with injury are usually one of the most prevalent unusual quality events at PACE. As with the previous years, most falls are either a result of non-use of durable medical equipment or lack of family supervision of participants who are at risk for falls at home. In 2022, due to the ongoing COVID-19 pandemic, we saw an increase in reporting of infectious disease cases especially in Quarter 1 and in Quarter 3 with different COVID-19 Omicron subvariant related surges. All COVID-19 cases by PACE participants are reported to CMS and DHCS, as well as state and local government.



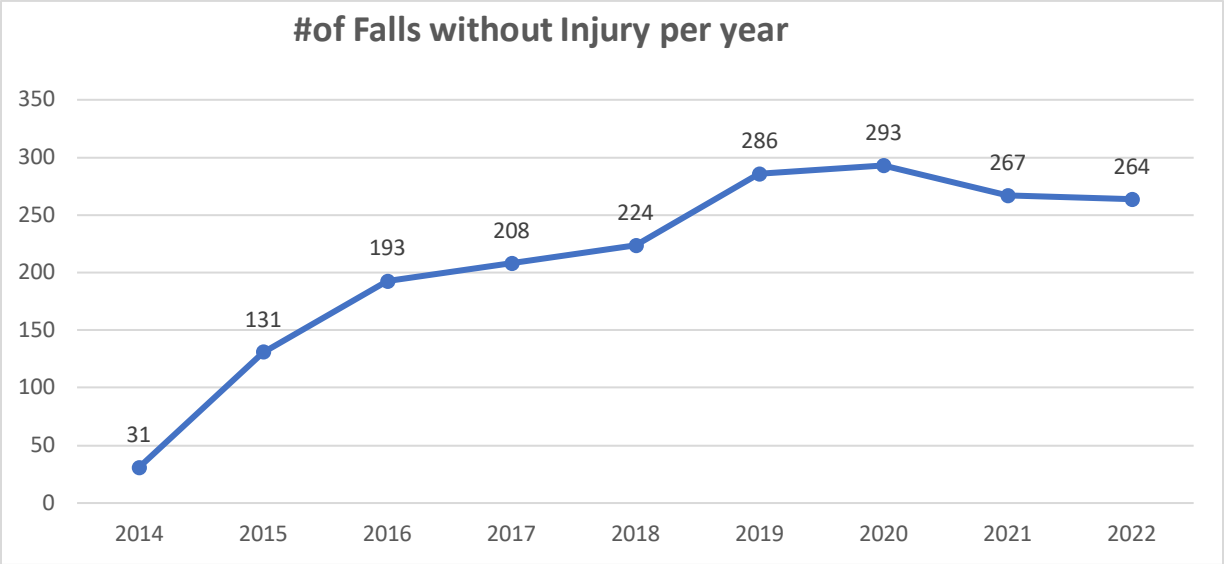
Medication Errors

A total of 2 medication errors were reported in 2022, both in Q3. One of the medication errors (timing) was attributable to PACE clinic staff error. In response to the staff error, education and training were implemented for the staff member as well as all nurses. Another error (dosage) was made by a technician at contracted pharmacy. In this case, we requested a corrective action plan from the pharmacy, and they complied with this request. Neither error resulted in any injury to participants. No further incidents have occurred.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2022



As in previous years, we have continued to maintain a relatively low number of falls. In 2022, we saw a decrease from 2021 figures. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima Health PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal of continued decreasing fall trends.

Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, continue to collaborate to develop participant-specific strategies for fall prevention. PACE is using an individualized approach to falls. Once any of the disciplines get information from participants and/or families via wellness calls related to a fall, they will send a Clinic Service Request to clinic and rehab for quick intervention. Rehab then reaches out to participant/family to provide immediately education and follow-up. If further evaluation and skilled rehab is warranted, PACE will ask the participant to do an in-person visit at PACE center. In this way, PACE maintains a direct response to each and every fall reported in a timely manner.

Denials of Prospective Enrollees

In 2022, three prospective enrollees were denied enrollment by the State. In each case, the prospective enrollee's health and safety would be jeopardized by living in a community setting.

Quality Initiatives

In 2022, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes though the COVID-19 pandemic. 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 three quality initiatives in 2022 were:

- COVID-19 Booster Vaccine Quality Initiative.
  - This initiative focused on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022. Through massive coordination efforts by PACE staff, we were able to exceed this goal and >95% of eligible participants ended 2022 with *at least* 1 booster dose of vaccine.
- Telehealth Engagement Quality Initiative
  - This initiative focused on accelerating the adoption and utilization of telehealth by the PACE participants. The goal for 2022 was that ≥ 66% or participants will have access to telehealth platforms such as VSEE. Unfortunately, we were unable to meet this goal in 2022, but will continue to research way to improve telehealth access for our participant population in 2023.
- Advance Health Care Directive
  - This initiative focused on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2022. At the end of 2022 we had reached 40% of participants with a scanned AHCD. In 2023 we will keep this quality intuitive and with a fully staffed and trained social work team, we anticipate meeting our goal in 2023.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2023

1. **Improve the Quality of Care (QOC) for Participants**
   a. Updating the COVID-19 booster immunization quality element to ensure as many eligible participants are vaccinated against COVID-19 with the latest recommended vaccines.
   b. Raising goals in care of diabetic participants to match the new highest level of care (HEDIS 95th percentiles) in areas such as eyes exams, and blood pressure and nephropathy monitoring.
   c. Ensuring that all participants receive preventative health care and diagnostic monitoring such as DEXA scans to look at bone mineral density.
   d. Continued efforts to reduce falls at home including new element to include home assessment review for repeat fallers.
2. **Ensure the Safety of Clinical Care**

a. 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. New quality initiatives related to dental grievances are introduced in the 2023 Quality Workplan.
b. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
c. Raising goals in reducing potential harmful drug/disease interactions in the elderly to match the highest level of care (HEDIS 95th percentiles).

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 participants.
        ii. Continue to refine the ER Diversion program to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
    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.
        ii. PACE will continue to leverage CalOptima Health's Provider Relations department to ensure that the specialist network meets the needs of PACE.
4. **Improve Participant Experience**
    a. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement. Use of transportation logs to resolve participant minor transportation issues immediately as they are reported.
    b. Once participants return to the PACE Day center at full capacity, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.
5. **Ensure Appropriate Access and Availability**
    a. Reopening of access to ACS sites will continue through 2023.
    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. Will continue to bring specialists in to provide specialty care within the PACE clinic.

SUMMARY

CalOptima Health 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: 2022 PACE QI EVALUATION

2022 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
QI22.01	Improve the Quality of Care for Participants	**2021 PACE QAPI Plan and Work Plan Annual Evaluation**	2021 PACE QAPI Plan will be evaluated by March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI22.02	Improve the Quality of Care for Participants	**2022 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI22.03	Improve the Quality of Care for Participants	**Influenza Immunization Rates**	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2022	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2022	12/31/2022	PACE Clinical Operations Manager	91%	Not Met	N/A	N/A	53%	Not Met	93%	Not Met	93%	Not Met
QI22.04	Improve the Quality of Care for Participants	**Pneumococcal Immunization Rates**	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager	95%	Met	88%	Not Met	87%	Not Met	88%	Not Met	88%	Not Met
QI22.05	Improve Quality of Care for Participants	**COVID-19 Immunization Rates**	≥95% of eligible participants will have had their COVID-19 vaccination by December 31st, 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager	97%	Met	98%	Met	98%	Met	98%	Met	98%	Met
QI22.06	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, 2022	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	12/31/2022	PACE Clinical Operations Manager and PACE Clinical Medical Director	90%	Not Met	92%	Not Met	96%	Met	94%	Not Met	94%	Not Met
QI22.07	Improve the Quality of Care for Participants	**Diabetes Care**	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th 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	12/31/2022	PACE Clinical Medical Director	74%	Not Met	72%	Not Met	72%	Not Met	71%	Not Met	72%	Not Met
QI22.08	Improve the Quality of Care for Participants	**Diabetes Care**	> 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th 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	12/31/2022	PACE Clinical Medical Director	95%	Met	99%	Met	99%	Met	96%	Met	96%	Met
QI22.09	Improve the Quality of Care for Participants	**Diabetes Care**	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th 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	12/31/2022	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI22.10	Improve the Quality of Care for Participants	**Osteoporosis**	>= 90% of participants with the diagnosis of Osteporosis will have treatment initiated by PCP	PACE participants with diagnosis of osteoporosis will be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.	Quarterly	01/01/2022	PACE Clinical Medical Director	97%	Met	98%	Met	98%	Met	99%	Met	98%	Met
QI22.11	Ensure the Safety of Clinical Care	**Falls at Home Clasified as CMS Reportable Quality Incidents**	<= 207 Falls per 1000 per year	Falls with injury will be mornitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Center Manager	49	Met	53	Met	54	Met	59	Met	59	Met
QI22.12	Improve the Quality of Care for Participants	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents**	<27.24% (Comparable to the 2020 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	12/31/2022	PACE Clinical Medical Director	17%	Met	18%	Met	19%	Met	22%	Met	19%	Met
QI22.13	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**	<3.47% (Comparable to the 2020 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	12/31/2022	PACE Clinical Medical Director	3%	Met	6.1%	Not Met	0.0%	Met	0.0%	Met	2.0%	Met
QI22.14	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 of 90 MME/day will be reevaluated monthly by their treating provider in 2022.	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	12/31/2022	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI22.15	Improve the Quality of Care for Participants	**Medication Reconciliation Post Discharge (MRP)**	≥90% of participants will have their medications reconciled within 15 days of hospital discharge in 2022	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022	PACE Pharmacist	100%	Met	100%	Met	100%	Met	96%	Met	99%	Met
QI22.16	Ensure Appropriate Access and Availability	**Improve Access to Specialty Care**	≥85% of specialty care authorizations will be scheduled within 14 business days in 2022 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022	PACE Clinical Operations Manager	91%	Met	91%	Met	95%	Met	90%	Met	92%	Met
QI22.17	Ensure Appropriate Access and Availability	**Improve Access to PACE Care: Increase Telehealth Engagement**	≥66% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2022	Community-Based Program Manager	54%	Not Met	53%	Not Met	51%	Not Met	57%	Not Met	54%	Not Met
QI22.18	Ensure Appropriate Use of Resources	**Reduce Acute Hospital Day Utilization**	<3,330 hospital days per 1000 per year	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	12/31/2022	PACE Clinical Director	3,863	Not Met	4,283	Not Met	4,412	Not Met	4,426	Not Met	4,426	Not Met
QI22.19	Ensure Appropriate Use of Resources	**Reduce Emergency Room Utilization**	<850 emergency room visits per 1000 per year	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	12/31/2022	PACE Clinical Director	833	Met	901	Not Met	856	Not Met	810	Met	810	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
QI22.20	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<14% 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	12/31/202	PACE Clinical Director	16%	Not Met	14%	Not Met	19%	Not Met	23%	Not Met	18%	Not Met
QI22.21	**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	12/31/2022	PACE Center Manager	3.12%	Met	4.2%	Not Met	4.17%	Not Met	3.69%	Met	3.80%	Met
QI22.22	**Improve Participant Experience**	**Enrollment/Disenrollment**	Increase the Qualified Lead to Enrollment conversion rate to 60% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022	PACE Marketing and Enrollment Manager	79%	Met	74%	Met	73%	Met	76%	Met	76%	Met
QI22.23	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2022	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	12/31/2022	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI22.24	**Improve Participant Experience**	**Transportation**	≥92% of all transportation rides will be on-time in 2022	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	12/31/2022	PACE Center Manager	99%	Met	100%	Met	99.0%	Met	94%	Met	98%	Met
QI22.25	**Improve Participant Experience**	**Transportation**	≥92% on the Overall Satisfaction with Transportation Services - Weighted Average (2021 PACE National Average) on the 2022 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 Transportation program	Annually	12/31/2022	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%	Not Met
QI22.26	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2022 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.	Annually	12/31/2022	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82%	Met
QI22.27	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2022 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	12/31/2022	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~~ CalOptima Health Program All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

2023~~2~~

PACE Quality Improvement Subcommittee Chairperson:

_____ _____

Donna Frisch~~Richard Helmer~~, M.D. ____Date
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. Date

Board of Directors Acting Chairperson:

_____ _____

Clayton Corwin ~~Andrew Do~~ Date

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~~**Supervisor, First District**~~

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health'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~~ CalOptima Health PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the ~~CalOptima~~ CalOptima Health 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~~ CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health'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~~ CalOptima Health PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan 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~~ CalOptima Health PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g.

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California Board of Nursing, etc.).
- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- ~~Assure~~ compliance with regulatory requirements of all responsible agencies.

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- **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 Directives 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 quality improvement.
  - 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.

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Organizational and Committee Structure

~~CalOptima~~ CalOptima Health Board of Directors provides oversight and direction to ~~CalOptima~~ CalOptima Health 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~~ CalOptima Health — including the ~~CalOptima~~ CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's~~'~~s Quality Improvement Committee (QIC) described in CalOptima Health's~~'~~s state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate 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 Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a 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 have been identified as critical to participants, ~~families~~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 elements 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

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indicate significant over/under utilization.

Membership
Membership will be flexible based on those with knowledge of the specific issues being ~~addressed, but~~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 Center 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
The PACE Member Advisory Committee (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 upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. -Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular 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.

2023~~2~~ Committee Organization Structure — Diagram

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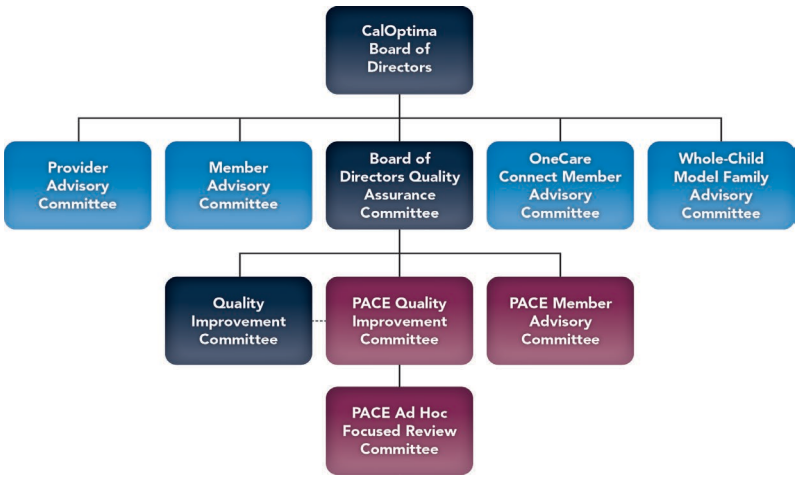

QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

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.

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- 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/Reportable Quality Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza Immunizations Rates
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants with diagnosis of Guillain Barre
            - ~~o~~ Participants who allergic to Influenza vaccine
    - ~~-~~Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enroll~~ed~~ in the program in December 2023~~1~~
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants who allergic to Pneumococcal vaccine
    - COVID-19 Bivalent Booster Immunization Rates
        - Exclusion criteria:
            - ~~Participants who enrolled in the program in December 2022~~Participants who enroll in the program in December 2023
            - Participants who have not already received their initial doses of COVID-19 vaccine
            - Participants who have recently tested positive for COVID-19, or at provider's discretion based on health history.
    - ~~Infection Control: Respiratory Infection Rates~~
    - Advanced Health Care Planning: POLST Completion
        - Exclusion criteria:
            - Participants who have been enrolled <6 months.
    - Diabetes Care: 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 measurement year
                    - For Q1 2023, look at October 1 2022 or earlier
            - Exclusion criteria:
                - Participants who have dx of Palliative Care Approach, ICD-10 Z515
                - Participants who have a dx of Frailty, ICD-10 R54
                - Participants who are 76 years and older as of December 31, 2023
                - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
                - ~~o~~
    - ~~Advance Health Care Planning: Advanced Health Care Directive Completion~~
    - Diabetes Care: Annual Eye Exams

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- The following inclusion and exclusion criteria will be in place for this measure:
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - Enrolled for at least six months during measurement year
      - For Q1 2023, look at October 1 2022 or earlier
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z515
    - Participants who are 76 years and older as of December 31, 2023
    - Participants who are legally blind.

~~- 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:
      - Diagnosis of Diabetes Mellitus
      - Enrolled for at least six months during measurement year
        - For Q1 2023, look at October 1 2022 or earlier
    - Exclusion criteria:
      - Participants who have dx of Palliative Care Approach, ICD-10 Z515
      - Participants who are 76 years and older as of December 31, 2023
      - Participants with End Stage Renal Disease

  ~~- 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~~

- Monitoring ~~of treatment for~~ Participants for ~~with~~ Osteoporosis
  - The following inclusion and exclusion criteria will be in place for this measure:
    - Inclusion criteria
      - Any participant who has a fall in 2023
- Reduction of all reported fall through home visits and follow up by Rehabilitation team with repeat fallers. ~~Falls at Home Classified as CMS Reportable Quality Incidents~~
    - Exclusion criteria:

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- Participants who have a fall in a hospital or skilled nursing facility.

- 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:~~Inclusion criteria:
      - Diagnosis of Dementia
      - Continuous enrollment throughout year (enrolled for at least a year)
        - For Q1 2023, Look at enrollment from 3/1/22 and before
        - For Q2 2023, Look at enrollment from 6/1/22 and before
        - For Q3 2023, Look at enrollment from 9/1/22and before
        - For Q4 2023, Look at enrollment from 12/1/22 and before
      - Participants who are 66 years and older as of December 31, 2023
    - Exclusion criteria:
      - Participants who have dx of Palliative Care Approach, ICD-10 Z515
      - Participants with Schizophrenia or Bipolar Disorder
    - ~~Continuous enrollment throughout year~~
    - ~~Participants who are 66 years and older as of December 31, 2022~~
    - ~~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 Nonaspirin NSAIDS or Cox2 Selective NSAIDs
  - The following inclusion and exclusion criteria will be in place for this measure:
    - Inclusion criteria:
      - Participants with diagnosis of CKD 3,4, or 5/End Stage Renal Disease.
      - Continuous enrollment throughout year
        - For Q1 2023, Look at enrollment from 3/1/22 and before
        - For Q2 2023, Look at enrollment from 6/1/22 and before
        - For Q3 2023, Look at enrollment from 9/1/22and before
        - For Q4 2023, Look at enrollment from 12/1/22 and before
      - Participants who are 66 years and older as of December 31,

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2023
- Exclusion criteria:
  - Participants who have dx of Palliative Care Approach, ICD-10 Z515
  - TOPICAL NSAIDS such as Voltaren (Diclofenac) gel may be excluded from this list since they have minimal systemic absorption.
- ~~Inclusion criteria:~~
  - ~~Continuous enrollment throughout year~~
  - ~~Participants who are 66 years and older as of December 31, 2022~~
- ~~Exclusion criteria:~~
  - ~~Participants who are end of life (less than six months)~~

- Opioids at High Dosage Monitoring by PCPs.
- Medication Reconciliation Post Discharge from Hospital or Skilled Nursing Facility.
- Access to Specialty Care services.

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~~ CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of~~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 shared with~~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, The PACE QI manager as well as either the PACE Director or the PACE Medical Director and will be immediately shared with via telephone

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and/or written letter with information about additional rights to appeal. ~~the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.~~

- Continued integration of telehealth to expand access to care through the continued COVID-19 pandemic and beyond.
- 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 Center Manager ~~QI department~~ will monitor transportation services with periodic ride~~- alongs~~alongs. The times gathered during the ride~~- alongs~~alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant 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.
- 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 SAA~~ 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

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Unusual Quality Incidents

- When unusual incidents meet~~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 outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections. ~~.~~
    - 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.
    - Elopement by cognitively impaired participants.
    - Adverse drug reactions.
    - Foodborne disease 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 corrective plan 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

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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 are ~~is~~ presented to the PQIC on a quarterly basis. The program's ~~three~~ quality initiatives in 2023~~2~~ are:
  - ~~COVID-19 Booster Vaccine Quality Initiative.~~
    - ~~This initiative will focus on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.~~
  - ~~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. The PACE Community Based Services Program Manager will implement a plan to increase prt telehealth access. The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.~~
  - Advance Health Care Directive
    - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2023~~2~~.
  - Dental Satisfaction
    - This initiative will focus on increasing participant satisfaction with

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contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a specialist *outside of PACE*, to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2023.

- Transportation Satisfaction
  - This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter.

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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.

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APPENDIX A (SEE ATTACHMENT)

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~~2022~~ 2023 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI22.01~~ QI23.01	**Improve the Quality of Care for Participants**	~~2022~~ 2022 **PACE QAPI Plan and Work Plan Annual Evaluation**	~~2021~~ 2022 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2023 ~~March 1st, 2022~~	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	~~3/1/2022~~ 3/8/22	PACE Medical Director
~~QI22.02~~ QI23.02	**Improve the Quality of Care for Participants**	~~2022~~ **2023 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee March 2023 ~~1st, 2022~~	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	~~3/1/2022~~ 3/8/22	PACE Medical Director
~~QI22.03~~ QI23.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2023 ~~2022~~	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2023 ~~2022~~	~~12/31/2022~~ 12/31/2023	~~PACE Clinical Operations Manager~~ PACE Medical Director
~~QI22.04~~ QI23.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	≥94% of eligible participants will have completed their ~~had their PCV23~~ pneumococcal vaccination by December 31st, 2023 ~~2022~~	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023 ~~2022~~)	Quarterly	~~12/31/2022~~ 12/31/2023	~~PACE Clinical Operations Manager~~ PACE Medical Director
~~QI22.05~~ QI23.05	**Improve Quality of Care for Participants**	**COVID-19 Booster Immunization Rates**	≥ ~~80~~95% of eligible participants will have had their COVID-19 Bivalent Booster Vaccine ~~vaccination~~ by December 31st, 2023 ~~2022~~	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023 ~~2022~~)	Quarterly	~~12/31/2022~~ 12/31/2023	~~PACE Clinical Operations Manager~~ PACE Medical Director
~~QI22.06~~ QI23.06	**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,~~2022~~ 2023	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	~~12/31/2022~~ 12/31/2023	PACE Clinical Operations Manager and PACE Medical Director
~~QI22.07~~ QI23.07	**Improve the Quality of Care for Participants**	**Diabetes Care**	>84.21% ~~81.50%~~ of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2021 ~~2020~~ MEDICARE Quality Compass HEDIS 95th 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 in maintaining healthy blood pressure.	Quarterly	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.08~~ QI23.08	**Improve the Quality of Care for Participants**	**Diabetes Care**	> 85.42% ~~82.77~~% of Diabetics will have an Annual Eye Exam (Comparable to the 2021 ~~2020~~ MEDICARE Quality Compass HEDIS 95th 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 in maintaining healthy vision.	Quarterly	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.09~~ QI23.09	**Improve the Quality of Care for Participants**	**Diabetes Care**	> 98.78% ~~98.30%~~ of Diabetics will have Nephropathy Monitoring (Comparable to the 2021 ~~2020~~ MEDICARE Quality Compass HEDIS 95th 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 in maintaining kidney function.	Quarterly	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.10~~ QI23.10	**Improve the Quality of Care for Participants**	**Osteoporosis**	~~>= 90% of participants with the diagnosis of Osteporosis will have treatment initiated by PCP~~ 100% of participants who have a fall will have a bone density scan to assess for osteoporosis	~~PACE participants with diagnosis of osteoporosis will be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.~~ Medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of reported fall	Quarterly	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI22.11~~ QI23.11	Ensure the Safety of Participants ~~Clinical Care~~	~~Falls at Home Clasified as CMS Reportable Quality Incidents~~ Reduce Percentage of Falls Reported by PACE Enrollees	~~<= 207 Falls per 1000 per year~~ <72 falls reported per quarter in 2023	~~Falls with Injury will be monitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement.~~ The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls.	Quarterly	~~12/31/2022~~ 12/31/2023	PACE Center Manager
~~QI22.12~~ QI23.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<24.64% ~~27.24%~~ (Comparable to the 2021 ~~2020~~ MEDICARE Quality Compass HEDIS 95th 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	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.13~~ QI23.13	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	<2.62% ~~3.47%~~ (Comparable to the 2021 ~~2020~~ MEDICARE Quality Compass HEDIS 95th 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	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.14~~ QI23.14	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 of 90 MME/day will be reevaluated monthly by their treating provider in 2023.	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. (Exclusion: Participants who have a diagnosis of Palliative Care)	Quarterly	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.15~~ QI23.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 10 ~~15~~ days of hospital and/or skilled nursing facility discharge in ~~2022~~ 2023	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	~~12/31/2022~~ 12/31/2023	PACE Pharmacist
~~QI22.16~~ QI23.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥ 88 ~~85~~% of specialty care authorizations will be scheduled within 14 business days in ~~2022~~ 2023 ~~(exclusions defined in QI Plan)~~	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	~~12/31/2022~~ 12/31/2023	PACE Clinical Operations Manager
~~QI22.17~~ ~~QI23.17~~	~~Ensure Appropriate Access and Availability~~	~~Improve Access to PACE Care: Increase Telehealth Engagement~~	~~≥66% of members will be able to engage in telehealth visits~~	~~Increase the % of participants who are utilizing the telehealth platform.~~	~~Quarterly~~	~~12/31/2022~~ ~~12/31/2023~~	~~Community Based Program Manager~~
~~QI22.18~~ QI23.17	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	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. (Exclusion: Participants who have Long Term Acute Care Hospitalizations of >90days).	Quarterly	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI22.19~~ QI23.18	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	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	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.20~~ QI23.19	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 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	~~12/31/2022~~ 12/31/2023	PACE ~~Clinical~~ Medical Director
~~QI22.21~~ QI23.20	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	~~12/31/2022~~ 12/31/2023	PACE Center Manager
~~QI22.22~~ QI23.21	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to ~~60~~ 65% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	~~12/31/2022~~ 12/31/2023	PACE Marketing and Enrollment Manager
QI23.22	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, to develop strategies for improvement.	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager
QI23.23	Improve Participant Experience	Disenrollment	Maintain a PACE participant attrition rate of ≤10 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants.	Quarterly	~~12/31/2022~~ 12/31/2023	PACE Center Manager and PACE Director
~~QI22.23~~ QI23.24	Improve Participant Experience	Transportation Performance	I00% of transportation trips will be less than 60 minutes in 2023 ~~2022~~	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	~~12/31/2022~~ 12/31/2023	PACE Center Manager
~~QI22.24~~ QI23.25	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2023 ~~2022~~	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	~~12/31/2022~~ 12/31/2023	PACE Center Manager
~~QI22.25~~ QI23.26	Improve Participant Experience	Transportation Satisfaction	≥93.6 ~~92~~% on ~~the Overall~~ Satisfaction with Transportation Services ~~(2020~~ 2022 PACE National Average) on the 2023 ~~2022~~ 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 Transportation program	Annually	~~12/31/2022~~ 12/31/2023	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI22.26~~ QI23.27	Improve Participant Experience	~~Increase~~ Participant Satisfaction with Meals	≥71.1% on Satisfaction with Meals ~~summary score~~ (~~2020~~ 2022 PACE National Average) on the 2023 ~~2022~~ 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.	Annually	~~12/31/2022~~ 12/31/2023	PACE Center Manager
~~QI22.27~~ QI23.28	Improve Participant Experience	~~Increase~~ Overall Participant Satisfaction	≥88.6% on the Overall Satisfaction-Weighted Average (~~2020~~ 2022 PACE National Average) on the 2023 ~~2022~~ 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	~~12/31/2022~~ 12/31/2023	PACE Director

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CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2023

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D. **Date**

Board of Directors Acting Chairperson:

Clayton Corwin **Date**

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health'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 Health PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima Health 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 Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health'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 Health PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan 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 Health 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.
    - Assure 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 Directives 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 quality improvement.
    - Monitor and track falls occurring in the PACE Day Center, 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

CalOptima Health Board of Directors provides oversight and direction to CalOptima Health 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 Health — including the CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate 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 Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a 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 have 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 elements 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 indicate significant over/under utilization.

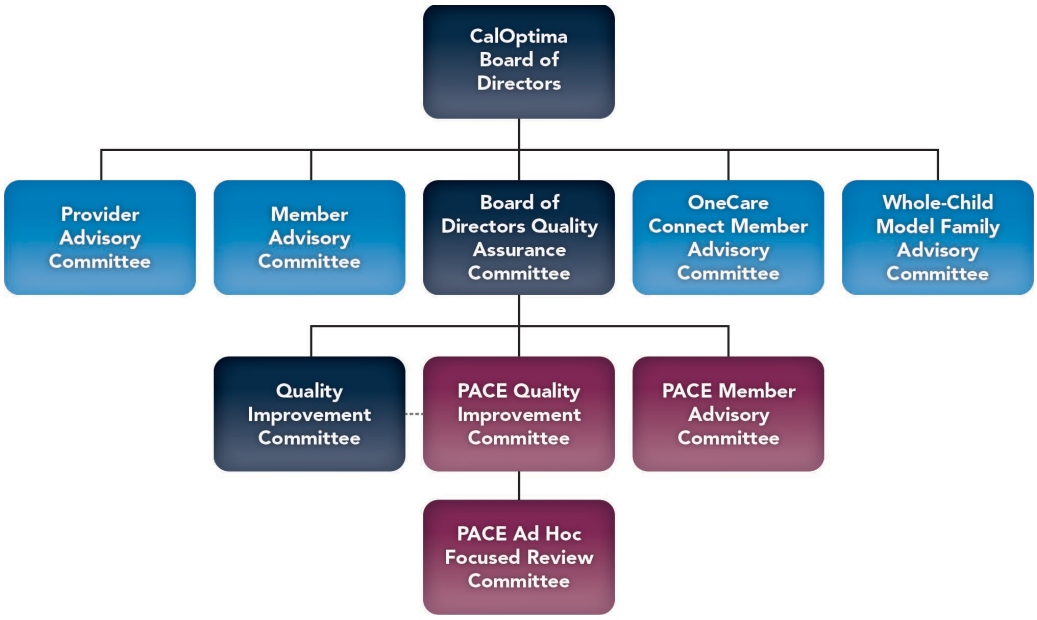
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program 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 Center 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
The PACE Member Advisory Committee (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 upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular 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.

2023 Committee 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 Data

- Unusual Incidents/Reportable Quality Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza Immunizations Rates
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants with diagnosis of Guillain Barre
            - Participants who allergic to Influenza vaccine
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 2023
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants who allergic to Pneumococcal vaccine
    - COVID-19 Bivalent Booster Immunization Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 2023
            - Participants who have not already received their initial doses of COVID-19 vaccine
            - Participants who have recently tested positive for COVID-19, or at provider's discretion based on health history.
    - Advanced Health Care Planning: POLST Completion
        - Exclusion criteria:
            - Participants who have been enrolled <6 months.
    - Diabetes Care: 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 measurement year
                    - For Q1 2023, look at October 1 2022 or earlier
            - Exclusion criteria:
                - Participants who have dx of Palliative Care Approach, ICD-10 Z515
                - Participants who have a dx of Frailty, ICD-10 R54
                - Participants who are 76 years and older as of December 31, 2023
                - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Diagnosis of Diabetes Mellitus

        - Enrolled for at least six months during measurement year
            - For Q1 2023, look at October 1 2022 or earlier
    - Exclusion criteria:
        - Participants who have dx of Palliative Care Approach, ICD-10 Z515
        - Participants who are 76 years and older as of December 31, 2023
        - Participants who are legally blind.

- Diabetes Care: Nephropathy Monitoring
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Diagnosis of Diabetes Mellitus
            - Enrolled for at least six months during measurement year
                - For Q1 2023, look at October 1 2022 or earlier
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants who are 76 years and older as of December 31, 2023
            - Participants with End Stage Renal Disease
- Monitoring Participants for Osteoporosis
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria
            - Any participant who has a fall in 2023
- Reduction of repeat falls through home visits and follow up by Rehabilitation team with repeat fallers.
        - Exclusion criteria:
            - Participants who have a fall in a hospital or skilled nursing facility.
- 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:
            - Diagnosis of Dementia
            - Continuous enrollment throughout year (enrolled for at least a year)
                - For Q1 2023, Look at enrollment from 3/1/22 and before
                - For Q2 2023, Look at enrollment from 6/1/22 and before
                - For Q3 2023, Look at enrollment from 9/1/22and before
                - For Q4 2023, Look at enrollment from 12/1/22 and before

        - Participants who are 66 years and older as of December 31, 2023
    - Exclusion criteria:
        - Participants who have dx of Palliative Care Approach, ICD-10 Z515
        - Participants with Schizophrenia or Bipolar Disorder

- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Participants with diagnosis of CKD 3,4, or 5/End Stage Renal Disease.
            - Continuous enrollment throughout year
                - For Q1 2023, Look at enrollment from 3/1/22 and before
                - For Q2 2023, Look at enrollment from 6/1/22 and before
                - For Q3 2023, Look at enrollment from 9/1/22and before
                - For Q4 2023, Look at enrollment from 12/1/22 and before
            - Participants who are 66 years and older as of December 31, 2023
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - TOPICAL NSAIDS such as Voltaren (Diclofenac) gel may be excluded from this list since they have minimal systemic absorption.
- Opioids at High Dosage Monitoring by PCPs.
- Medication Reconciliation Post Discharge from Hospital or Skilled Nursing Facility.
- Access to Specialty Care services.

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 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 Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of 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 shared with 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 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 The PACE QI manager as well as either the PACE Director or the PACE Medical Director and will be immediately shared with via telephone and/or written letter with information about additional rights to appeal.
- Continued integration of telehealth to expand access to care through the continued COVID-19 pandemic and beyond.
- 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 Center Manager 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 participant 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.
- 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 to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents, 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 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 meet 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 outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
    - 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.
    - Elopement by cognitively impaired participants.
    - Adverse drug reactions.
    - Foodborne disease outbreak.
    - Burns 2nd degree or higher.
- 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 corrective plan 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 are presented to the PQIC on a quarterly basis. The program's quality initiatives in 2023 are:
    - Advance Health Care Directive
        - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2023.

- Dental Satisfaction
  - This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a specialist *outside of PACE*, to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2023.

- Transportation Satisfaction
  - This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter.

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 A (SEE ATTACHMENT)

2023 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.01	**Improve the Quality of Care for Participants**	**2022 PACE QAPI Plan and Work Plan Annual Evaluation**	2022 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2023	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/8/2023	PACE Medical Director
QI23.02	**Improve the Quality of Care for Participants**	**2023 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee March 2023	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/8/2023	PACE Medical Director
QI23.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2023	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2023	12/31/2023	PACE Medical Director
QI23.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2023	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023)	Quarterly	12/31/2023	PACE Medical Director
QI23.05	**Improve Quality of Care for Participants**	**COVID-19 Booster Immunization Rates**	≥ 80% of eligible participants will have had their COVID-19 Bivalent Booster Vaccine by December 31st, 2023	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023)	Quarterly	12/31/2023	PACE Medical Director
QI23.06	**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,2023	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	12/31/2023	PACE Clinical Operations Manager and PACE Medical Director
QI23.07	**Improve the Quality of Care for Participants**	**Diabetes Care**	>84.21% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th 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 in maintaining healthy blood pressure.	Quarterly	12/31/2023	PACE Medical Director
QI23.08	**Improve the Quality of Care for Participants**	**Diabetes Care**	> 85.42% of Diabetics will have an Annual Eye Exam (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th 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 in maintaining healthy vision.	Quarterly	12/31/2023	PACE Medical Director
QI23.09	**Improve the Quality of Care for Participants**	**Diabetes Care**	> 98.78% of Diabetics will have Nephropathy Monitoring (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th 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 in maintaining kidney function.	Quarterly	12/31/2023	PACE Medical Director
QI23.10	**Improve the Quality of Care for Participants**	**Osteoporosis**	100% of participants who have a fall will have a bone density scan to assess for osteoporosis	Medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of reported fall.	Quarterly	12/31/2023	PACE Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.11	**Ensure the Safety of Participants**	**Reduce Percentage of Falls Reported by PACE Enrollees**	<72 falls reported per quarter in 2023	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total	Quarterly	12/31/2023	PACE Center Manager
QI23.12	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents**	<24.64% (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th 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	12/31/2023	PACE Medical Director
QI23.13	**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**	<2.62% (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th 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	12/31/2023	PACE Medical Director
QI23.14	**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 of 90 MME/day will be reevaluated monthly by their treating provider in 2023.	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. (Exclusion: Participants who have a diagnosis of Palliative Care)	Quarterly	12/31/2023	PACE Medical Director
QI23.15	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	≥90% of participants will have their medications reconciled within 10 days of hospital and/or skilled nursing facility discharge in 2023	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2023	PACE Pharmacist
QI23.16	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	≥ 88 % of specialty care authorizations will be scheduled within 14 business days in 2023	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2023	PACE Clinical Operations Manager
QI23.17	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	<3,330 hospital days per 1000 per year	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. (Exclusion: Participants who have Long Term Acute Care Hospitalizations of >90days).	Quarterly	12/31/2023	PACE Medical Director
QI23.18	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	<850 emergency room visits per 1000 per year	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	12/31/2023	PACE Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.19	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<14% 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	12/31/2023	PACE Medical Director
QI23.20	**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	12/31/2023	PACE Center Manager
QI23.21	**Improve Participant Experience**	**Enrollment/Disenrollment**	Increase the Qualified Lead to Enrollment conversion rate to 65% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager
QI23.22	**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, to develop strategies for improvement	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager
QI23.23	**Improve Participant Experience**	**Disenrollment**	Maintain a PACE participant attrition rate of ≤10 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants.	Quarterly	12/31/2023	PACE Center Manager and PACE Director
QI23.24	**Improve Participant Experience**	**Transportation Performance**	I00% of transportation trips will be less than 60 minutes in 2023	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	12/31/2023	PACE Center Manager
QI23.25	**Improve Participant Experience**	**Transportation Performance**	≥92% of all transportation rides will be on-time in 2023	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	12/31/2023	PACE Center Manager
QI23.26	**Improve Participant Experience**	**Transportation Satisfaction**	≥93.6% Satisfaction with Transportation Services (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2023	PACE Center Manager
QI23.27	**Improve Participant Experience**	**Participant Satisfaction with Meals**	≥71.1% Satisfaction with Meals (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2023	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.28	**Improve Participant Experience**	**Overall Participant Satisfaction**	≥88.6% on the Overall Satisfaction-Weighted Average (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the PACE program	Annually	12/31/2023	PACE Director

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2022 PACE Quality Improvement Plan Evaluation

Quality Assurance Committee Meeting
March 8, 2023

Dr. Donna Frisch, PACE Medical Director

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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2022 PACE Accomplishments

- PACE has continued to maintain and follow the Public Health Emergency COVID-19 guidance to ensure we are following all protocols
- Only 3.8% of participants resided in Long-Term Care
- 93% influenza immunization rate
- 98% COVID-19 immunization rate
  - 95% with at lease one additional booster dose
- Quality of Diabetes Care
  - 96% had annual eye exam completed
  - 100% had nephropathy monitoring

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PACE CalOptima Health

2022 PACE Accomplishments

- 100% medication reconciliation within 14 days following a hospital discharge
- 94% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Transportation on-time performance of 98%
- Overall participant satisfaction score of 89% compared to national average of 88.5%

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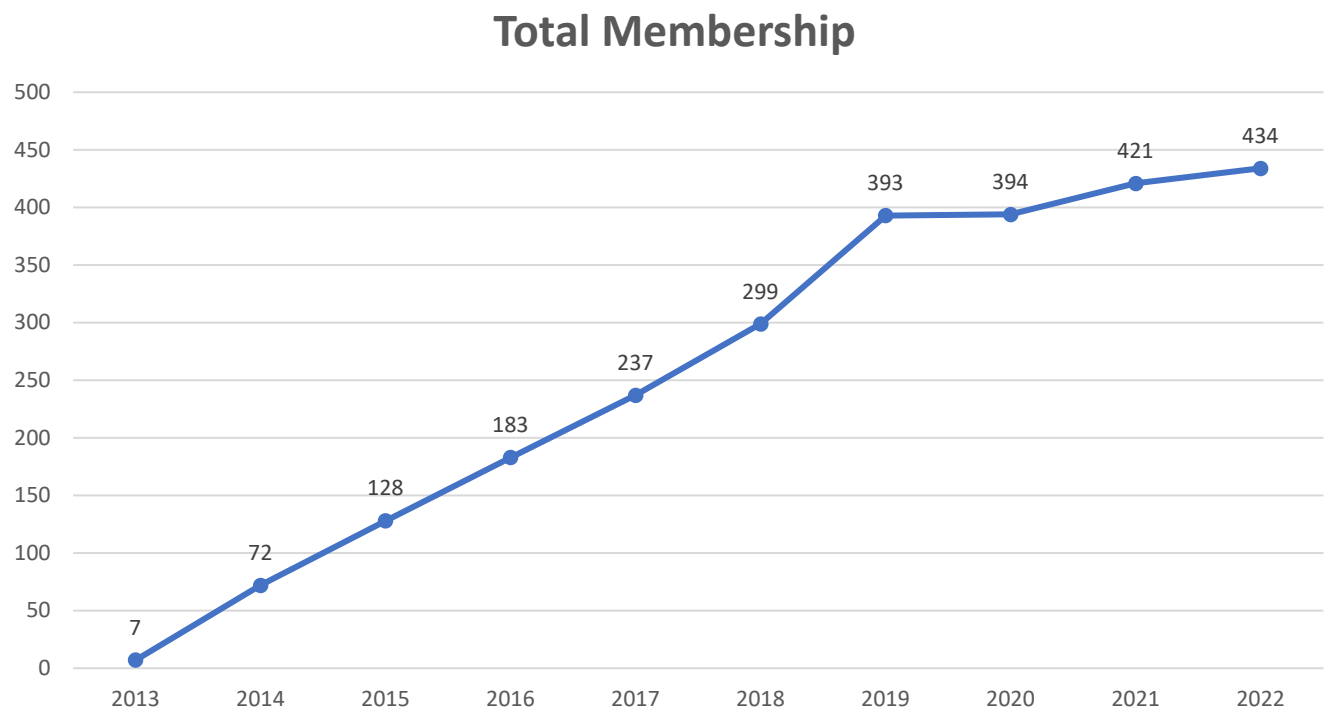
PACE CalOptima Health

PACE Membership Growth 2013-2022



2022 saw PACE's highest number of active enrollees since opening in 2013

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PACE CalOptima Health

Elements 8 & 9: Comprehensive Diabetes Care

Higher Is Better		Medicare Quality Compass 2020 HEDIS Percentiles			
Domain	**2022 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
Annual Diabetic Eye Exams	**96%**	69.34%	76.3%	80.78%	**82.77%**
Nephropathy Monitoring	**100%**	94.74%	96.11%	97.81%	**98.3%**

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PACE CalOptima Health

Elements 12 & 13: Potential Harmful Drug/Disease Interactions in the Elderly

Lower Is Better		Medicare Quality Compass 2020 HEDIS Percentiles			
Domain	**2022 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**19%**	37.26%	32.58%	27.24	**24.03%**
Chronic Renal Failure + NSAID	**2%**	9.24%	6.25%	3.47%	**2.47%**

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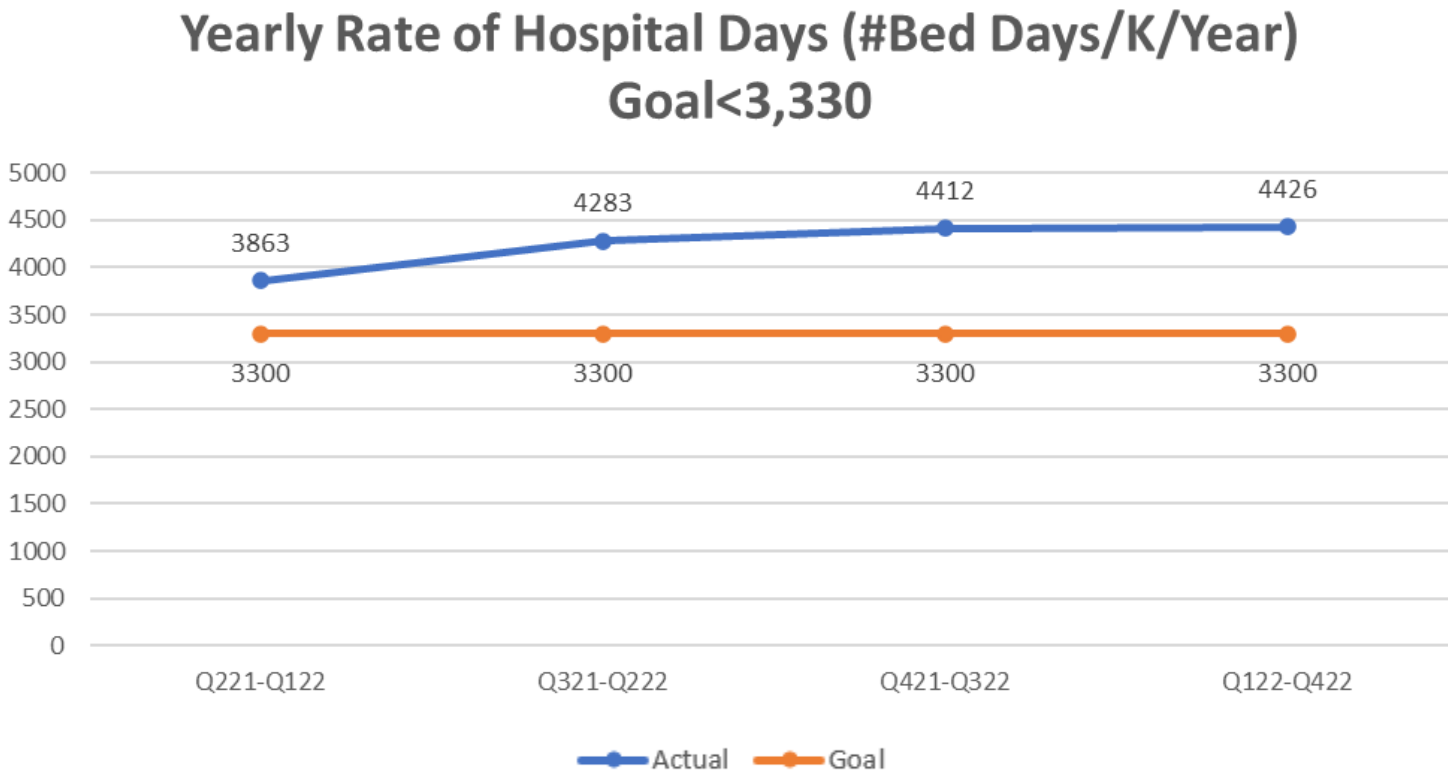
PACE CalOptima Health

Element 18: Hospital Bed Days



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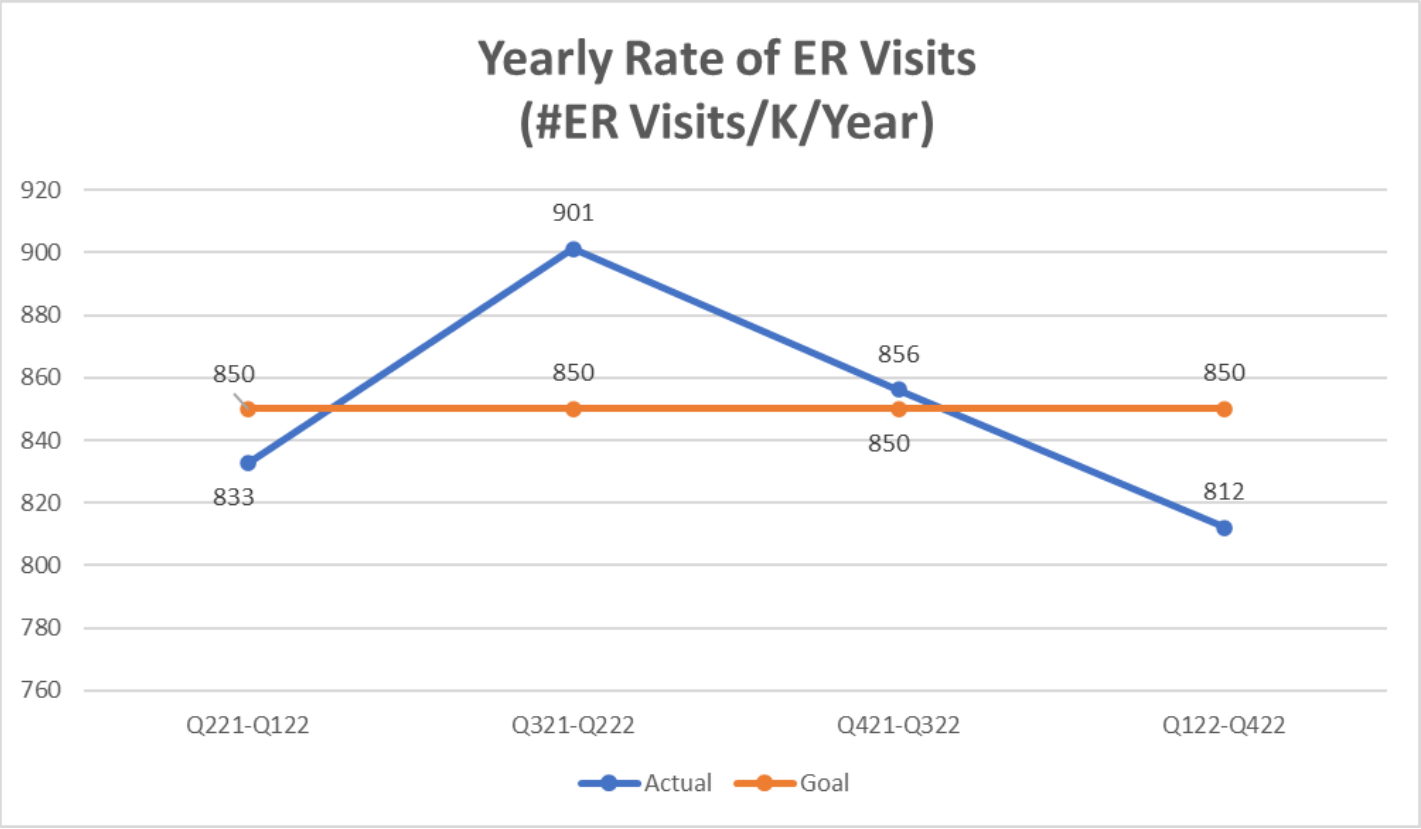
Element 19: ER Utilization



Goal of reducing ER visits met in 2022

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PACE CalOptima Health

Element 27: Annual Participant Satisfaction Survey Results (Goal: ≥ 88% on Overall Weighted Score)

Domain	2021 CalOptima PACE	2022 CalOptima PACE	2022 National PACE Average
Transportation	96%	**89%**	**93.6%**
Center Aids	95%	**96%**	**91.7%**
Home Care	90%	**85%**	**85.8%**
Medical Care	93%	**87%**	**89.7%**
Health Care Specialist	88%	**85%**	**89.0%**
Social Worker	97%	**95%**	**94.5%**
Meals	80%	**82%**	**71.1%**
Rehabilitation Therapy and Exercise	91%	**93%**	**93.0%**
Recreational Therapy	81%	**84%**	**79.1%**
General Service Delivery	92%	**92%**	**86.4%**
Overall Weighted Score	91%	**89%**	**88.6%**

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PACE CalOptima Health

Opportunities for Improvement in 2023

- Improve the Quality of Care (QOC) for Participants
  - Updating COVID-19 booster immunization quality element to ensure as many eligible participants are vaccinated against the latest recommended vaccines.
  - Raising goals in care of diabetic participants to match the highest level of care (HEDIS 95th percentiles) in areas such as eyes exams, and blood pressure and nephropathy monitoring.
  - Ensuring that all participants receive preventative health care and diagnostic monitoring such as DEXA scans to look at bone mineral density.
  - Continued efforts to reduce falls at home including new element to include home assessment review for repeat fallers.

Opportunities for Improvement in 2023

- Ensure the Safety of Clinical Care
  - 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. New quality initiatives related to dental grievances are introduced in the 2023 Quality Workplan.
  - Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
  - Raising goals in reducing potential harmful drug/disease interactions in the elderly to match the highest level of care (HEDIS 95th percentiles).

Opportunities for Improvement in 2023

- Ensure the Appropriate Use of Resources
  - Inpatient/ER Utilization
    - Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
    - Continue to refine the ER Diversion program to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
  - Specialty Care
    - 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. PACE will continue to leverage CalOptima Health's Provider Relations department to ensure that the specialist network meets the needs of PACE.

Opportunities for Improvement in 2023

- Improve Participant Experience
  - Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement. Use of transportation logs to resolve minor transportation issues immediately when they are reported.
  - Once participants return to the PACE Day center at full capacity, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.

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Opportunities for Improvement in 2023

- Ensure Appropriate Access and Availability
  - Reopening of access to Alternate Care Setting sites will continue through 2023.
  - 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.
  - Will continue to bring specialists in to provide specialty care within the PACE clinic.

Questions?

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2023 PACE Quality Improvement Plan Description

Quality Assurance Committee Meeting
March 8, 2023

Dr. Donna Frisch, PACE Medical Director

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2023 PACE Quality Improvement (QI) 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
- Updated to address COVID-19 vaccination recommendations

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PACE CalOptima Health

2023 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

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PACE CalOptima Health

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

- Removed
  - *Improve Access to PACE Care: Increase Telehealth Engagement.*
    - In 2022, PACE was able to return to many of our in-person services including scheduled assessments and request for clinic services for immediate needs. Because of this, we are removing the telehealth element from our workplan, however, we do plan to continue exploring way to expand telehealth access and utilization with our PACE participants as an operational issue in 2023.

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PACE CalOptima Health

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

- Modified Elements
  - *Falls at Home Classified as CMS Reportable Quality Incidents*
    - This element has been modified for 2023 to address that PACE is interested in a reduction of repeat falls. The element description is now "*Reduce Percentage of Falls Reported by PACE Enrollees".* The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls.

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

- Modified Elements Continued
  - *Osteoporosis*
    - This element has been modified for 2023 to change the focus from ensuring that participants with osteoporosis are treated (consistently above goal in 2022) to make sure PACE is assessing all participants for osteoporosis regardless of risk factors. For this element, the medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of the reported fall.

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

- Added Elements
  - *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%. PACE will review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths, to develop strategies for improvement.
  - *Disenrollment/Attrition*
    - Maintain a PACE participant attrition rate of ≤10 %. PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants in 2023.

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PACE CalOptima Health

2023 PACE Quality Initiatives

- Advanced Health Care Directive
  - The goal for 2023 is ≥ 50% of participants having a completed AHCD in 2023.
- Dental Services Satisfaction
  - The goal for 2023 is ≤ 1 dental related grievance per quarter in 2023.
- Transportation Services Satisfaction
  - The goal for 2023 is ≤ 3 transportation related grievance per quarter in 2023.

Recommended Action

- Recommend approval of the 2023 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Receive and File 2022 CalOptima Health Quality Improvement Program Evaluation and Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Linda Lee, MPH, Executive Director, Quality Improvement, (714) 867-9655

Recommended Actions

- Receive and File the 2022 CalOptima Health Quality Improvement Program Evaluation, and
- Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan.

Background

CalOptima Health's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to CalOptima Health members, which aligns with its vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. The QI Program 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.

CalOptima Health's QI Program is 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 Health members.

The 2022 Quality Improvement Program Evaluation analyzes the core clinical and service indicators to determine if the 2022 QI Program has achieved its key performance goals during the year.

CalOptima Health had the following achievements in 2022:

- September 2022: Received a 4 out of 5 in NCQA's Medicaid Health Plan rating.
- October 2022: Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 Orange County (OC) Visionaries in a special publication of the LA Times OC.
- November 2022: CalOptima Health and the Orange County Health Care Agency won the Public-Private Partnership Award from the Orange County Business Council Turning Red Tape Into Red Carpet Awards.
- November 2022: Received the mPulse award for Most Improved Consumer Experience with its multilingual, two-way SMS texting program that addressed language barriers around food security.

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In 2022, CalOptima Health remained committed to innovative approaches to improving quality of care and quality of service. CalOptima Health expanded strategies to improve member health outcomes, member experience, and provider engagement by adding a OneCare Pay for Value program to promote improvement in quality of care for the dual eligible member population. CalOptima Health also added a Hospital Quality Program to improve health outcomes and patient safety in the acute care setting.

Discussion

CalOptima Health staff has updated the 2023 QI Program and Workplan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

The 2023 QI Program is based on the Board-approved 2022 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 Health's strategic initiatives.

The revisions are summarized as follows:

1. Updated existing program initiatives to align with health equity and current operational practices.
2. Updated 2023 quality improvement goals and objectives:
    - Goal 1 – Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
    - Goal 2 – Improve quality of care and member experience by obtaining NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
    - Goal 3 – Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and a Hospital Quality.
3. Updated new program initiatives
    - Health Equity Framework.
    - Comprehensive Community Cancer Screening and Support Program.
    - Five-Year Hospital Quality Program.
4. Updated the QI Program staffing and resources to reflect current organizational structure.
5. Updated the QI Committee Structure by removing OneCare Connect committees.
6. Removed programs that sunset in 2022.
7. Updated sections in the QI Program to reflect current operational processes and workflows.

The 2023, the CalOptima Health QI Program and Work Plan will be flexible and able to align with strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

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2023 QI Program Recommendations:

1. Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic with programs that support
2. Early detection and cancer screening for breast, cervical, colorectal and lung cancer
3. Targeted interventions and member engagement to well-child visits, blood lead screening and childhood immunizations.
4. Incorporate Social Determinants of Health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
5. Expand quality initiatives to improve member experience, focused on increasing member access to care.

The recommended changes to CalOptima Health's QI Program are reflective of current clinical operations and are necessary to meet the requirements specified by the Centers of Medicare and Medicaid Services, California Department of Health Care Services and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2023 QI Program has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2022-23 Operating Budget. Staff will include expenditures for the period of July 1, 2023, through December 31, 2023, in the FY 2023-24 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachments

1. 2022 Quality Improvement Program Evaluation
2. 2023 Quality Improvement Program and Work Plan DRAFT FINAL (Redline version)
3. Proposed 2023 Quality Improvement Program and Work Plan DRAFT FINAL (Clean version)
4. PowerPoint Presentation: 2022 QI Evaluation, 2023 QI Program and Work Plan

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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2022

QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

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2022 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors - Quality Assurance Committee Chair:

_____ _____

Trieu Tran, M.D. **Date**

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2022 Quality Improvement Program Evaluation of Overall Effectiveness

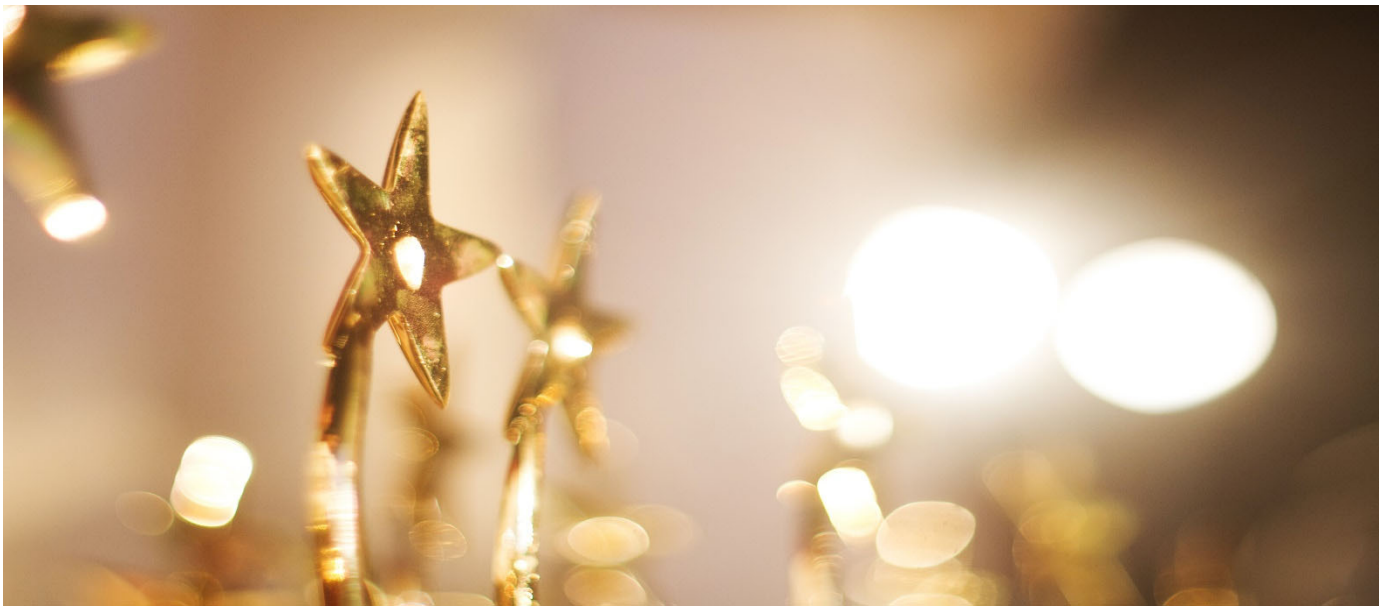
EXECUTIVE SUMMARY

The 2022 Quality Improvement (QI) Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved key performance goals during the year. This evaluation focuses on quality activities initiated during measurement years 2021 and 2022, which impacted results in 2022, to improve health care and services available to CalOptima Health members.

The QI Program for 2022 outlined the major program initiatives. Threaded into the initiatives continued to be impact of the COVID-19 pandemic and the ongoing public health emergency that began in 2020. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance documents with flexibility in regulations addressing member access to care during the pandemic.

In December 2020, when the COVID-19 vaccine became available, CalOptima Health pivoted to quickly and equitably assist our members in protecting themselves and their families. Strategies included providing each member a $25 Target gift card incentive per dose, participating in the DHCS COVID-19 Vaccination Incentive Program, and collaborating with Orange County Health Care Agency on the Vaccine Equity Pilot Program, which directly allocated COVID-19 vaccine doses to health network providers and community health centers. CalOptima Health also conducted multifaceted member engagement and outreach and supported vaccination clinics for diverse communities to address vaccine hesitancy. CalOptima Health is committed to continuing member outreach, targeting disproportionately affected communities and increasing vaccination rates until community immunity is reached.

In 2022, the QI Program Initiatives aligned with CalOptima Health's strategic priorities with a focus on health equity, social determinants of health, member engagement, improved access to care and improved quality outcomes. CalOptima Health remained focused on advancing QI initiatives to achieve 2022 QI goals and objectives to provide members with access to quality health care services. CalOptima Health continued to utilize the Plan-Do-Study-Act (PDSA) approach to developing initiatives in 2021 that continued into 2022. These initiatives are focused on long-term improvement efforts for selected high-priority measures. In 2023, based on the 2022 QI Program Evaluation, QI will continue to support a strategy, as identified in the 2023 QI Program, that aligns with CalOptima Health's strategic priorities and regulatory requirements and focuses on activities and incentives that will improve member engagement, access to care and quality outcomes. The 2023 QI Work Plan will profile key areas that offer opportunities for improvement to be implemented or continued as outlined in the 2023 QI Program.



2022 Achievements

Awards and Recognitions

September 2022: CalOptima Health received a rating of 4 out of 5 in the National Committee for Quality Assurance's Medicaid Health Plan Ratings 2022. No other Medi-Cal Plan in California earned a rating higher than 4 out of 5. This is the eighth year in a row that CalOptima Health has received this distinction.

October 2022: Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 OC Visionaries in a special publication of the LA Times OC. Their selection acknowledges their noteworthy accomplishments and impact at CalOptima Health and in Orange County. Fewer than 20 individuals were recognized within the health care industry.

November 2022: CalOptima Health won an award from mPulse Mobile for Most Improved Consumer Experience with its multilingual, two-way SMS texting program that addressed language barriers around food security. The program educated members on the availability and benefits of CalFresh, which provides monthly food benefits to low-income individuals and families, encouraging members to apply through a direct link provided in two-way text workflows. The innovative program expanded to seven languages and allowed members to respond in their native language with simple statements like, "I already have CalFresh" or "I want to apply."

November 2022: CalOptima Health and the Orange County Health Care Agency won the Public-Private Partnership Award from the Orange County Business Council Turning Red Tape Into Red Carpet Awards. The award recognizes both agencies for the launch of Be Well OC's campus in the city of Orange as a first-of-its-kind center that provides comprehensive behavioral health care to improve mental health and substance use disorder services for Orange County residents.

Review of 2022 Recommendations

CalOptima Health's QI Goals and Objectives were aligned with the agency's 2022–23 Strategic Goals.

- Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
- Improve quality of care and member experience by maintaining NCQA Health Plan Rating of 4.0, and at least a Four-Star Rating for Medicare.
- Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

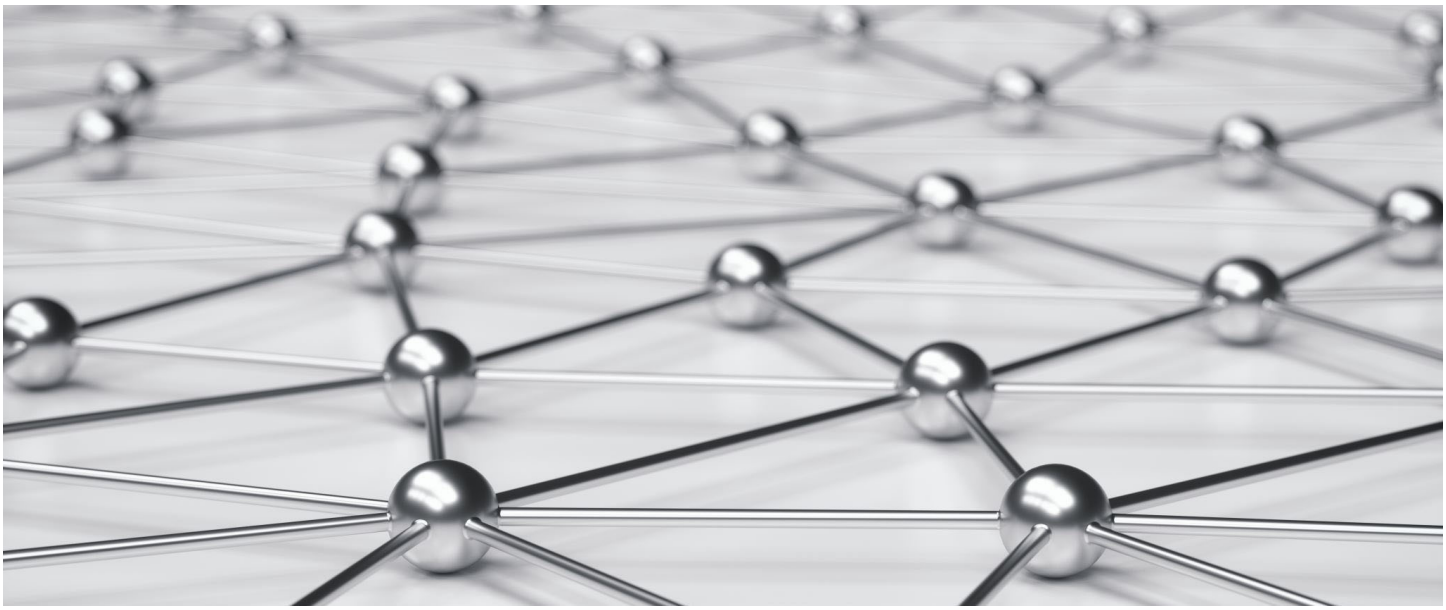
These top three priority goals were chosen to be aligned with CalOptima's strategic objectives, the COVID-19 pandemic, as well as continued goals related to access to care and NCQA accreditation. The 2022 QI Work Plan details the planned activities to meet the COVID-19 vaccine aim, which include strategies for immunization, targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards, as measured by the annual Timely Access study. All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

Recommendations for 2023

This past year continued to bring uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that has impacted lives locally, nationally and globally. CalOptima Health's QI Program and Work Plan for 2023 will be flexible to align with the new strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

Based on the 2022 QI Program Evaluation, in addition to continuing to advance CalOptima Health's mission and improve quality outcomes of members, we recommend the following initiatives and projects to drive improvements that impact members.

- Incorporate Social Determinants of Health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs
- Collaborate with external stakeholders and partners in comprehensive assessments of members.
- Develop robust community-based interventions using analytical tools, such as geo-mapping, in collaboration with community partners and entities that have a good understanding of the target population barriers and behaviors
- Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, Interactive Voice Response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology
- Expand collaboration on quality initiatives in partnership with health networks to broaden and expand the reach of coordinated data sharing to close gaps in care
- Continue to implement Enhanced Care Management (ECM) and Community Supports as part of California Advancing and Innovating Medi-Cal (CalAIM)
- Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic with programs that support:
    1. Early detection and cancer screening for breast, cervical, colorectal and lung cancer.
    2. Targeted interventions and member engagement for well-child visits, blood lead screening and childhood immunizations.
- Align initiatives to support the DHCS 2022 Comprehensive Quality Strategy
- Implement DHCS Population Health Management Program
- Expand CalAIM team to support implementation of oversight strategy, and provision of services that best meet member needs
- Continue to promote treatment for healthy cholesterol levels for members with diabetes and support compliance with diabetic HbA1c testing and eye exams through provision of member incentives and education
- Implement Homeless Response team and Street Medicine Program to support members experiencing homelessness
- Expand behavioral health interventions to support complex mental health needs and improve follow up after hospital utilization
- Promote prenatal and postpartum care for members through provision of member incentives and education and reduce health disparities through targeted interventions
- Expand quality initiatives to improve member experience, focused on increasing member access to care



SECTION 1: QUALITY IMPROVEMENT PROGRAM STRUCTURE

Activities in the 2022 Quality Improvement (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 Health's Board of Directors.

For 2022, CalOptima Health had adequate staffing and 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 Services (GARS) Committee.

The QIC consists of eight CalOptima Health medical directors, four CalOptima Health staff and seven health network medical director representatives, plus an Orange County Health Care Agency behavioral health representative. The Committee is supported by additional CalOptima Health staff. The QIC had exceptional participation from external and internal practitioners as well as staff. Annually, a draft of the QI Program is presented to the QIC for review and approval. Committee members are asked to provide feedback on quality initiatives and activities presented in the program. QIC has oversight of the QI Program and Work Plan. Thorough the year, CalOptima Health staff and practitioners review progress reports and updates on quality activities that address necessary improvements in the quality of care delivered by all providers in any setting and take appropriate action to improve upon Health Equity.

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 members.

QI Program Documents

- Annual Evaluation — Completed a comprehensive evaluation of the QI Program and QI Work Plan at the end of the fiscal year that assesses the performance on measures and indicators.
- Program Description — Developed and implemented a robust written QI Program description that focused on improving standards of care and addressing gaps in care identified in the prior year's evaluation. The organization enhanced the QI Program by including "new initiatives" in the QI Program description that will outline measurable goals and objectives that CalOptima Health will 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 based 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 and align with regulatory and accreditation requirements.
- Delegation Grid — Describes activities delegated to the health networks.
- Organizational Chart — Provides a visual presentation of the reporting structure of the QI Committee, its subcommittees, and its relationship to the CalOptima Health Board of Directors

Reviews of QI Documents

- CalOptima Health successfully completed reviews of all of the above documents with the QI committees during 2022. The documents were reviewed and approved by the CalOptima Health Board of Directors.
- Feedback from the practitioners who participated in the QI committee meetings was included in program documents (i.e., Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

- The QIC is the primary committee that is responsible for the QI Program, Work Plan and Evaluation, and reports to the Quality Assurance Committee (QAC) of the CalOptima Health Board of Directors
- The committee provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key QI documents in a timely manner
- The QIC reviewed and provided feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials and more
- The committee reviewed and approved the policies and procedures and made recommendations regarding policy decisions
- 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; and complaints and appeals. Part of the feedback included specific actions that CalOptima Health could take to improve performance
- The committee received quarterly reports from the Credentialing and Peer Review Committee (CPRC), Utilization Management Committee (UMC), Member Experience Committee (MEMX), Grievance and Appeals Resolution Services (GARS) and Whole Child Model Clinical Advisory Committee (WCM CAC). These reports were summarized and presented quarterly to the QAC

Assessment of QI Staff and Resources

CalOptima Health continues to dedicate significant resources and staffing to meet the needs of the QI Program. In 2022, the QI department added staff to support anticipated changes to the Department of Health Care Services (DHCS) requirements for Facility Site Review (FSR). In Q3 2022, the DHCS FSR and Medical

Record Review (MRR) tools and standards were implemented. Staff in Potential Quality Issues (PQI) were shifted to support quality of care grievance reviews. Credentialing delegation oversight was transferred from QI to the Audit & Oversight department in December 2022. To support the development of the Health Equity Framework, a Manager of Population Health Management focusing on health equity was created. In addition, an Executive Director of Quality position was created, and this position will work closely with the Executive Director of Population Health Management to ensure staff has adequate support to meet the needs of the QI Program. The QI department also received support from other key departments within the organization, including but not limited to the following:

- Quality Analytics
- Population Health Management
- Behavioral Health Integration
- Case Management
- Member Services (including outreach and engagement)
- Provider Relations and Contracting

Review of System Resources

CalOptima Health has dedicated significant resources to ensuring there are 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 the Provider Relations, Network Management, GARS and Customer Service departments.

CalOptima Health also utilizes three enterprise systems for utilization and care management (GuidingCare by Altruista), claims payment (Facets) as well as credentialing data management (Cactus by Symplr). Although these systems are not integrated, data from the systems are stored in a data warehouse, and resources are allocated to create robust tools utilizing Tableau to analyze and generate quality reports, gaps in care reports and other relevant reports needed to support the QI Program. There is a robust data integration flow in place that allows the organization to use data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts as well as an ITS department that can support the reporting needs of the organization.

CalOptima Health issued a Request for Proposal (RFP) for both the utilization and care management system and credentialing, contracting and provider data management system. In 2022, CalOptima Health sought to contract with vendors who best meet system and business needs.

Overall Assessment of Program Structure

CalOptima Health had adequate staffing and resources required to meet the needs of the QI Program, in addition to organizational program requirements. CalOptima Health 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 about the development and implementation of the QI initiatives and programs. CalOptima Health continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. The medical directors and QI directors report the information to senior leadership.

The Charter was reviewed, and the following modifications were made: the committees may meet virtually or in-person, the Deputy Chief Medical Officer and Quality Medical Director were added and the subcommittees

of QIC were updated. In addition, the purpose and desired outcome of the committee will be added to each agenda, and the following responsibilities were added: review and assess compliance with QI and Health Equity standards and oversight of compliance issues including but not limited to timeliness of clinical care and services provided to members.

Program Oversight

2022 UM Program Evaluation

CalOptima Health direct networks CalOptima Health Community Network (CCN) and CalOptima Health Direct Network (COD) saw a downward movement between Q1 2022 to Q3 2022 in volume for one-day stays in inpatient facilities. There was a slight uptick in Q2 2022 by 0.5% and a decrease by 0.88% in Q3 for one-day stays. CalOptima health worked with the highest volume facility for one-day stays to pilot a treatment authorization nurse that was embedded in the Emergency Department (ED) to promote real time support for members to approve and coordinate ambulatory care prior to leaving the ED. All three quarters of 2022 showed Sepsis as the top diagnosis for inpatient, one-day stays. CalOptima health implemented weekly inpatient rounds with all nine adult facilities with the top 10 high-volume facilities and the pediatric weekly rounds are slated to start in Q1 of 2023. All-cause readmissions had a slight increase from Q1 22 to Q2 by .003% and a 14% decrease from Q1 to Q3 for all-cause readmits within 30 days for CalOptima Health's direct networks. -CalOptima Health had implemented rounds by Q3 with all five of the top facilities with greatest volume of readmissions within 30 days that included support of the internal complex discharge team and referrals to complex case management, Enhanced Case Management and CalAIM community supports. These efforts will continue into 2023 to address inpatient utilization trends.

Credentialing and Peer Review Committee (CPRC) Oversight

The purpose of the CPRC is to maintain a peer review and credentialing program that aligns with the regulatory and accreditation standards, promotes continuous improvement of the quality of health care provided by the CalOptima Health network, conducts peer-level review and evaluation of provider performance and credentialing information against CalOptima Health requirements and appropriate clinical standards, and investigates patient care outcomes that raise quality and safety concerns for corrective actions. In 2022, the committee met monthly, cancelling one meeting.

This year, the CPRC had one community physician resign due to retirement. In June, a new community physician was added who specializes in pulmonary and critical care medicine, and neurological critical care, and represents the Noble Mid-Orange health network. Additionally, the Committee added new CalOptima Health medical directors as they came aboard. In October, the Chair of the Committee transitioned to a new medical director. To date, the Committee consists of nine CalOptima Health medical directors and four community physicians representing various health networks. CalOptima staff and General Counsel provide support to the CPRC.

The CPRC continued to review credentialing, recredentialing, ongoing monitoring and peer review activities and trends. The committee also reviewed changes to all QI policies and procedures including those related to credentialing, potential quality issues and FSRs. This year, two separate Judicial Hearing Committees (JHC) were commenced and concluded in two separate cases. CPRC adopted the recommendation of each of the JHCs, which led to the termination and an 805 action against one physician.

In 2023, the committee plans to meet monthly and maintain committee member composition. The committee will review applicable NCQA audit measures and report any noncompliance of regulatory and/or accreditation to QIC.

Grievance and Appeals Resolution Services (GARS) Committee

The committee met quarterly in 2022. In an ongoing effort to identify initiatives to improve access to care and services, the committee analyzes member experience results. The GARS Committee reviewed for trends in dissatisfaction quarterly and the GARS department reports on actions taken to correct/improve the trend. The review includes categories of dissatisfaction, provider trends in quality of care and service complaints, complaints related to vendors, denial rates and reasons.

Reported during the year were efforts to improve trends including telephone accessibility, appointment availability and transportation.

In 2023, the committee plans to meet quarterly and maintain committee member composition. The committee will review applicable NCQA audit measures and report any noncompliance of regulatory and/or accreditation to QIC.

Member Experience Committee (MEMX) Oversight

The purpose of the MEMX is to improve the member experience and drive initiatives to achieve member experience goals established by the corporate strategic plan or QI Work Plan. The MEMX also ensures members have access to quality health care services for all product lines and programs.

In 2022, the committee met bimonthly, though one meeting was canceled. The committee is chaired by the Executive Director of Operations, has membership including the Chief Medical Officer and Quality Medical

Director, is represented by the business units that impact the member experience and is supported by staff in Quality Analytics. Reporting to the committee are the following workgroups: Timely Access and Network Adequacy Workgroups.

The committee reviewed the charter and made the following changes:

- Changed the title of the Co-Chair to Chair
- Added the Executive Director, Behavioral Health Services, and Director, Program Initiatives
- Added the Provider Action Workgroup to address non-clinical provider issues.

In 2022, the committee reviewed the Provider Satisfaction Survey questions and methodology. The survey was created to retrieve feedback from contracted providers as to what CalOptima Health does well and areas that need improvement. The survey was finalized, fielded July to September 2022, and resulted in the following areas of feedback:

- Increase reimbursement rates
- Difficulty contacting Claims, Customer Service and GARS departments
- Enhance online tools
- Issues with authorizations and referrals
- Improve contracting and credentialing processes
- Poor access to resources such as preauthorization denials and medications
- Difficulty contacting staff at CalOptima Health.

The committee also reviewed the Whole Child Model program for California Children's Services (CCS) participation in each specialty. It was identified that one health network was noncompliant for Physical Medicine and Rehabilitation. Action was escalated by the committee for resolution by the health network.

Finally, the committee reviewed non-clinical issues related to providers. The Provider Action Workgroup was developed to review and address these issues, which may include, for example, panel closures.

In 2023, the committee plans to meet quarterly and maintain committee member composition. The committee will review applicable NCQA audit measures and report any noncompliance of regulatory and/or accreditation to QIC.

Utilization Management Committee (UMC)

The purpose of the UMC is to provide oversight and direction for continuous improvements to the UM functions and activities performed by CalOptima Health that aligns with overall strategic goals and priorities. 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 efficiencies of the care and services provided to members.

The UM committee reviews and approves on an annual basis the core mission-aligned, regulatory and NCQA required artifacts including but not limited to UM Program description, Medical Necessity Criteria, UMC charter and UM program description. The committee provides guidance to the Pharmacy and Therapeutics and Benefits Subcommittees, both of which report to UMC.

UMC Scope and Responsibilities:

Provides oversight and overall direction for the continuous improvement of the UM Program consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated Health Networks as appropriate

- Oversees the UM activities and compliance with federal and state statutes and regulations, and 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, and 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 UM best practices used for selected diagnoses or disease classes
- Conducts under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring, and sets appropriate upper and lower thresholds for over/under utilization trend reports

The committee met quarterly in 2022 and plans to meet quarterly in 2023. The committee will continue to provide oversight and direction of UM functions and will report any noncompliance of regulatory and/or accreditation to QIC.

Pharmacy and Therapeutics (P&T) Committee

The CalOptima Health Pharmacy and Therapeutics (P&T) Committee is responsible for development of the drug formularies, which are based on sound clinical evidence, and are reviewed at least annually by practicing practitioners and pharmacists. The committee includes 13 voting members who are practicing physicians or pharmacists. At least one physician and one pharmacist are required to be experts in the treatment of elderly or disabled persons.

The P&T Committee meets a minimum of four times per year and reports to the UM Committee. In 2022, the committee met on February 17, May 19, August 18 and November 17.

P&T Committee Goals**:**

- To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima members.
- To meet DHCS and CMS formulary regulatory requirements.
- Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's strategic goals and priorities.
- Promote an interdisciplinary approach to driving continuous improvement in pharmacy utilization.
- Support compliance with regulatory and licensing requirements and accreditation standards related to pharmacy-related initiatives.
- Monitor, evaluate and act on pharmacy-related care and services members are provided to promote quality of care outcomes.

P&T Committee Responsibilities:

- Review new medications and prior authorization criteria as outlined in CalOptima Health policy GG.1409: Drug Formulary Development and Management and policy MA.6103: Pharmacy and Therapeutics Committee.

- Review individual requests for changes to the formularies from practitioners in the community.
- Review and update the formularies on an ongoing basis to ensure access to quality pharmaceutical care that is consistent with the program's scope of benefits.
- Review anticipated and actual utilization trends overall as well as for specific drug classes.
- Review and evaluate pharmacy-related issues related to delivery of health care to CalOptima Health members.
- Assess outcomes of pharmacy-related HEDIS and Medicare Star measures to drive improvements.
- Review and evaluate patterns of pharmaceutical care and key utilization performance indicators.
- Evaluate and make recommendations on pharmacy issues that pertain to CalOptima Health-wide initiatives, such as treatment guidelines, disease management programs, QI studies, etc.
- Review and make recommendations on selected pharmaceutical provider educational activities.
- Recommend pharmacy-related policy decisions.

In 2023, the P&T Committee plans to continue to meet quarterly and maintain the current committee member composition. They will report any noncompliance of regulatory and/or accreditation to QIC.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to evaluate and maintain the benefit set. The committee determines if new or revised codes require a prior authorization for each line of business within CalOptima Health that is aligned with regulatory, statutory, contractual or clinical best practice standards. The committee, as a subcommittee to UMC, oversees all revised and updated authorization rules.

In 2022, the committee met eight times, and in 2023, it plans to meet at least six times. The committee will maintain the current committee members composition and will report any noncompliance of regulatory and/or accreditation to QIC.

Whole Child Model Clinical Advisory Committee (WCM CAC)

In 2022, the committee met quarterly. At the February meeting, the committee revised its charter to add a pediatric pulmonologist since several of the California Children's Services (CCS)-related conditions require evaluation from a pulmonologist. The committee reviewed the following quality initiatives this year:

- Discussed an effort to engage UCLA providers to participate in the CalOptima Health network. UCLA agreed to move forward with pediatric organ transplantation for people younger than 21 years of age.
- Informed CalOptima Health providers of Neonatal Intensive Care Unit (NICU) MCG guideline changes.
- Analyzed Customer Service data identifying notable trends related to WCM members and recommended strategies for improvement.
- Developed workgroups to address members experiencing transplantation, hemophilia, aging-out of CCS services, and care coordination with the goal of ensuring a smooth transition of care.
- Reviewed data related to WCM members from supporting departments, including HEDIS MY2021 rates, utilization, behavioral health, grievance and customer data, influenza and COVID-19 immunization rates, and health network adequacy.

One physician left the committee in November, and that seat will be filled in 2023. Additionally, the committee added new CalOptima Health medical directors as they came aboard in 2022. The committee consists of eight CalOptima Health medical directors, one Orange County Health Care Agency psychiatrist, and nine community physicians representing various health networks. CalOptima Health staff provided support to the committee.

In 2023, the committee plans to meet at least quarterly and maintain the current committee member composition. The committee will review NCQA standards and report noncompliance of regulatory and/or accreditation to QIC.

Program Initiatives for 2022

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 members. The 2022 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 Long-Term Care (LTC) Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as 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 have 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 September 2021 revealed that Latinx people account for 45.9% of coronavirus deaths, in a state where they are 38.9% of the population, and Black people account for 6.7% of the deaths but are only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima Health identified opportunities to improve health equity as part of the QI Work Plan.

Orange County COVID-19 Nursing Home Prevention Program

The University of California, Irvine (UCI) COVID-19 Skilled Nursing Facility (SNF) Prevention Program developed a toolkit and implemented training to improve prevention and readiness and to restrict, to the extent

possible, the impact of the anticipated COVID-19 surge to Orange County SNFs and the local systems of care. The project included collaboration with Orange County Health Care Agency (OCHCA) and leveraging their efforts in developing the local public health response to clusters and cases in SNFs, as well as incorporating CDC and public health guidance.

Interventions

- UCI Prevention Team provided consultative services for COVID-19 prevention to contracted OC SNFs. Twelve SNFs received intensive training with weekly feedback of staff safety metrics. A total of 150 hours of consultation was provided to 31 additional SNFs.
- UCI created a free online toolkit available to all OC SNFs. Receiving more than 3,000 web views, the kit contained three modules, 51 documents and 20 videos.
- UCI distributed training materials to more 55 OC SNFs, including 1,100 informational wall-clings and 90 binders filled with education materials.
- UCI launched a confidential helpline for COVID-19 questions. More than 250 helpline inquires addressing questions about COVID-19 prevention, vaccines, safety, etc. were received.
- UCI hosted seven free webinars with invitations to all staff at OC SNFs.

Findings

UCI continued to conduct point prevalence sweeps of residents for multidrug-resistant organisms. UCI trained 12 SNFs for collection of surveillance samples.

Facility Type	Average Percentage of Residents with Completed Primary Vaccinations	Average Percentage of Staff with Completed Primary Vaccination	Average Residents Total Confirmed COVID-19	Average Residents Total COVID-19 Deaths	Average Staff Total Confirmed COVID-19	Average Staff Total COVID-19 Deaths
Intensive Training Group	90.6%	96%	114	16	118	1
All Other OC SNFs	89.6%	96.8%	85	11	93	>1
CA SNFs	89.6%	95.1%	78	8	82	>1

Intensive Training Group = 12 OC SNFs received intensive, hands-on prevention training; All Other OC SNFs = Did not receive intensive hands-on training, but had access to all training materials and consultations; CA SNFs = All California SNFs outside Orange County, did not receive prevention training from UCI

1. Analysis

This was an educational outreach project to reduce the spread of COVID-19 in OC SNFs. It was a two-year project, ending May 31, 2022. Baseline data was not collected. Although UCI met all the objectives, the data collected by CMS in August 2022 indicates the program was minimally effective when compared with SNFs not receiving prevention training.

2. Barriers

- High SNF staff turnover made it difficult to ensure all staff received the COVID-19 prevention training.

- Data was difficult to collect. UCI spent a sizeable amount of time measuring vaccine uptake, those receiving a vaccine, in OC SNFs. They found the actual uptake was far lower than the reported numbers. This was largely due to the challenge of identify staff due to time-off and staff working at multiple facilities.

3. Opportunities for Improvement

This program concluded in May 2022, so no further activity will be reported. Should CalOptima Health perform future programs with UCI, measurable goals and baseline metrics will be established, and will be reported quarterly.

COVID-19 Vaccination and Communication Strategy

On December 11, 2020, the Food and Drug Administration (FDA) used an Emergency Use of Authorization (EUA) to allow the administration of the COVID-19 vaccine in the United States.

On January 7, 2021, the CalOptima Health Board of Directors (BOD) approved the COVID-19 Member Vaccine Incentive Program (VIP). The goal of this program was to motivate members to obtain the required doses of COVID-19 vaccination by providing nonmonetary gift cards. The proposed efforts were funded through Intergovernmental Transfer (IGT) funds and awarded a $25 nonmonetary gift card per dose of the COVID-19 vaccine. The organizational goal was set to achieve a COVID-19 vaccination rate of 80% for all eligible members.

Today, the COVID-19 VIP eligibility has expanded to other brands, doses and younger age groups to align with the most up-to-date vaccination recommendations. Members who are 6 months of age and older may now qualify for a gift card. CalOptima Health also expanded the COVID-19 VIP eligibility criteria to include Kaiser Medi-Cal members as an eligible population. In addition to offering nonmonetary incentives, an essential strategy to promote vaccination efforts was tailored member education. The member education materials focused on the importance of vaccination, aimed to correct misconceptions and promoted community vaccination events.

1. COVID-19 Member Vaccine Incentive Program (VIP)

CalOptima Health has been committed to executing interventions that promote COVID-19 vaccinations. These include member health rewards as a part of the COVID-19 VIP; member and provider publications; social media messaging; text message campaigns; and vaccination events through collaborations with the Orange County Health Care Agency, community-based organizations and schools.

- COVID-19 VIP: CalOptima Health currently offers up to three health rewards to qualifying members who are vaccinated with the COVID-19 vaccine.
- Multiple member and provider campaigns were launched throughout the year providing education about COVID-19 and the vaccines. The campaigns included member and provider publications, social media posts on Facebook, Instagram and Twitter, and text messaging campaigns to members.
- CalOptima Health collaborated with the Orange County Health Care Agency, community-based organizations and schools to coordinate vaccination events. There was a total of 23 vaccination events in which qualified members for the COVID-19 VIP received a $25 gift card upon getting vaccinated.

2. Findings

As of October 31, 2022, out of all CalOptima Health eligible members ages 6 months and up (933,791), the total vaccinated membership was 553,542, which yields a total vaccination percentage of 59.3%. Review of the vaccination rates by race/ethnicity shows that most categories have achieved at least a 50% vaccination rate with Asian being the highest at 80.5% and Black being the lowest at 46.5%. See Table A: COVID-19 Vaccination Rates by Race/Ethnicity.

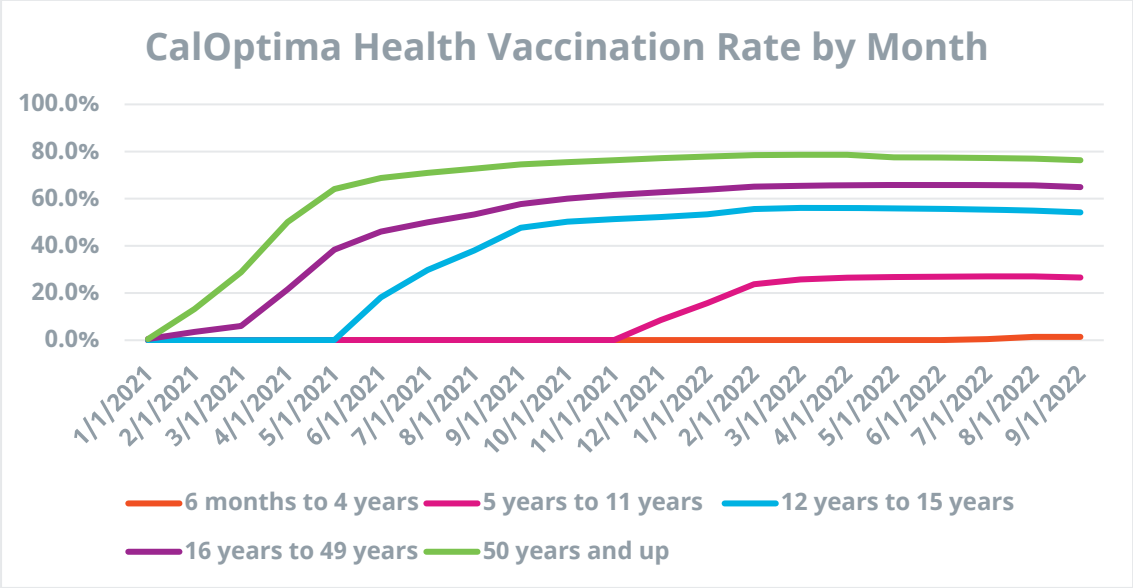
Table A: COVID-19 Vaccination* Rates by Race/Ethnicity

Vaccination Rates as of 10/31/2022	**Race/Ethnicity**					
	Alaskan Native/ American Indian	*Asian*	*Black*	*Hispanic*	*Others*	*White*
Numerator	788	147,894	7,872	215,760	98,027	83,201
Denominator	1,565	183,612	16,940	409,533	167,399	154,742
Rate	50.4%	80.5%	46.5%	52.7%	58.6%	53.8%

**Vaccination rate includes members who have been vaccinated with at least 1 dose of the COVID-19 vaccine.*

- CalOptima Health's COVID-19 VIP eligibility focuses on members in three programs. As of 10/31/2022, OneCare Connect (OCC) had reached an 81.8% vaccination rate, OneCare (OC) 83.9% and Medi-Cal (MC) 58.8%.
- Upon review of vaccination rates by age bands per month, there is a plateauing trend for most age groups. See Chart A: COVID-19 Member Vaccination Rates by Month.

Chart A: COVID-19 Member Vaccination* Rates by Month

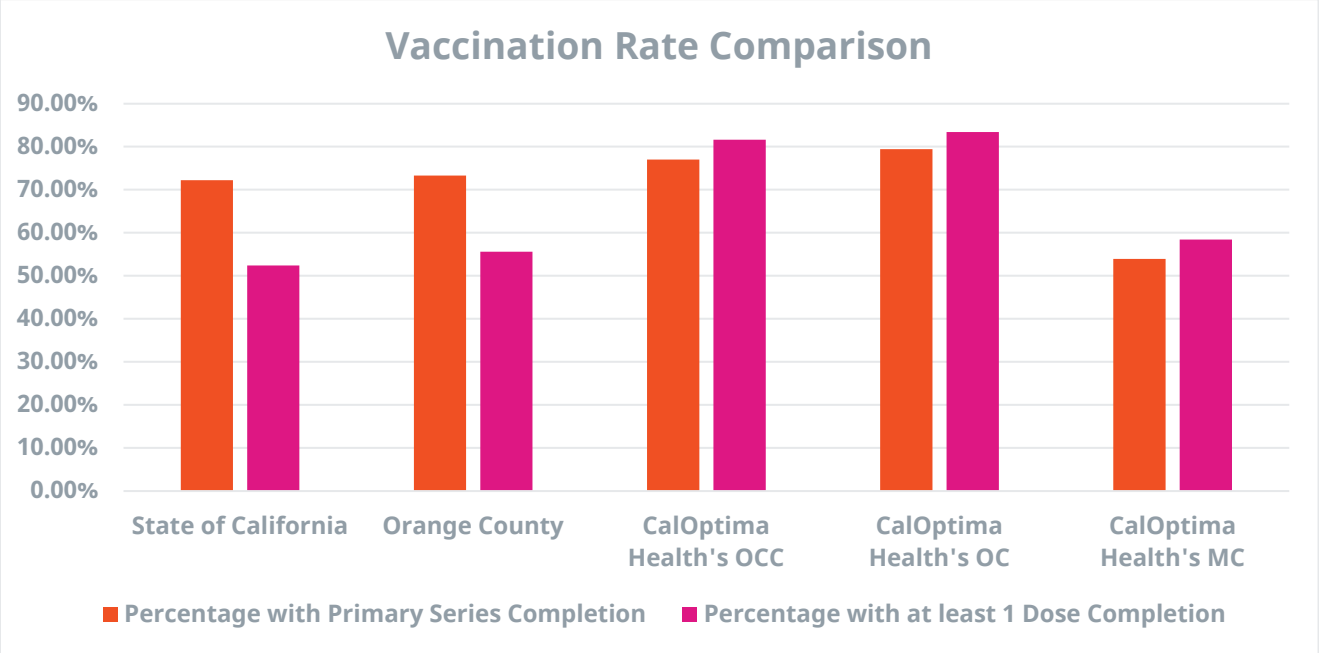


**Vaccination rate includes members who have been vaccinated with at least 1 dose of the COVID-19 vaccine.*

3. Analysis

a. OC and OCC vaccination rates have surpassed the organizational goal of 80% vaccination rate. OC and OCC populations were among the first group to be recommended the COVID-19 vaccine based risk level, and they have had the most time to begin inoculation. In addition, several outreach efforts have been performed by CalOptima Health since the inception of the COVID-19 VIP.

Chart B: COVID-19 Vaccination Rate Comparison



State and County data pulled from: https://www.dhcs.ca.gov/Documents/COVID-19/DHCS-COVID-19-Vaccine-Stats.pdf CalOptima Health data pulled from: https://dwtabpr.caloptima.org/#/site/CO/views/CalOptimaCOVID-19VaccineAnalysis/COVID-19VaccinatedMembersbyVaccinationStatusFullvsPartial?:iid=1

b. The continuous recommendations for age expansions and increase in dose approvals has made the denominator for the COVID-19 VIP MC population grow and has had an effect on vaccination rates for MC members. Upon further analysis, vaccinations among younger populations were met with increased hesitancy and Chart A shows that ages 6 months to 4 years have had a slow start after CDC approval.

c. Most members vaccinated with at least one dose of the COVID-19 vaccine have plateauing trends and do not show increasing numbers. This means that in general, most age groups are not starting their vaccination series at this time and the likelihood of beginning COVID-19 vaccine inoculation for those who are not vaccinated at all is minimal.

d. COVID-19 interventions focused on encouraging vaccinations and providing education through various means of communication. These strategies have been successful in driving member vaccinations as seen in vaccination rates among OC/OCC members. MC members ages 16 and up have plateaued at 70% and further interventions are needed for younger age groups to boost the overall MC vaccination rate of 58.8%.

4. Barriers

- CDC's continuous efforts to build on recommendations for the COVID-19 vaccine may have led to confusion surrounding vaccination guidelines for different age bands.
- Some members experienced COVID-19 vaccination hesitancy, especially for younger ages groups (6 months to 4 years).
- COVID-19 VIP is a passive gift card assignment; members do not need to submit any documentation to CalOptima Health to receive a health reward. Instead, CalOptima Health relies on multiple sources to receive member vaccination data (i.e., California Immunization Registry, claims and encounter data). The multiple data sources, and state lag time increased various data inaccuracies. This caused many members to experience a waiting period of several months after completing their COVID-19 vaccinations to receive incentives.
- COVID-19 VIP is not aligned with CDC's current recommendations. Staff is recommending a modification to the COVID-19 VIP to continue to encourage vaccine adherence and give younger age groups sufficient time start their inoculation.

5. Opportunities for Improvement

- CalOptima Health will provide continued updated booster promotion via publications to minimize misconceptions and provide education.
- CalOptima Health will create text messaging campaigns to survey members about the COVID-19 VIP program and provide educational links while encouraging members to get their updated boosters.
- CalOptima Health will work with multiple departments to continue to align recommendations for the COVID-19 VIP system flow and logic that feeds into assignment of COVID-19 health rewards.
- CalOptima Health will create a call center members to ask about the COVID-19 VIP program. This would bring value to the member experience because it gives members the opportunity to get clarification on questions or unclear guidelines and minimizes frustration that members may have about COVID-19 VIP program.
- Staff received approval of three modifications to the COVID-19 VIP program from the CalOptima Health Board in November 2022, which included an extension of the COVID-19 VIP to June 30, 2023, to provide ample time for younger age groups to receive vaccinated status, an increase of the rewards to four rewards to all qualifying members to encourage updated booster vaccinations, and to update all

communication tools to provide clear health reward guidelines and encourage member inoculation before the end of the COVID-19 VIP.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

In February 2022, DHCS launched the Comprehensive Quality Strategy (CQS), a 10-year quality vision to improve quality of life and eliminate health disparities focused on integrating a whole-system, person-centered and population health approach to care and building partnerships with Medi-Cal members and organizations in the community. The CQS focuses on the three target clinical areas: (1) Children's preventive care, (2) Behavioral Health Integration and (3) Maternal Care. It also establishes a CalAIM Population Health Management (PHM) Strategy to address member needs across a continuum of care.

Interventions

1. Continue to implement CalAIM
2. Plan and prepare for Health Equity Accreditation
    a. Purchased Health Equity Accreditation Standards
    b. Contracted with an NCQA Consultant to conduct a gap analysis related to Health Equity Accreditation
3. Conducted a PHM Readiness Assessment
4. Developed a CalOptima Health PHM Strategy that aligns with the DHCS PHM Strategy and Roadmap

Elements of the CQS are evaluated separately and the evaluation of each element can be found throughout the QI Evaluation.

Health Equity Workgroup and Social Determinants of Health (SDOH) Workgroup

In January 2022, the Health Equity and SDOH Workgroup (the workgroup) was formed as part of a larger organization-wide Equity Initiative, which aimed to create a culture of equity throughout the organization. Since its inception, the workgroup has remained active and engaged in building foundational knowledge of health equity concepts, co-creating a health equity definition and adapting a framework to guide health equity efforts.

Evaluation

1. Interventions/Strategies

Leveraging the Institute for Healthcare Improvement's health equity framework, the workgroup is anchoring their efforts in five areas: (1) Make health equity a strategic priority, (2) Develop structure and process to support health equity work, (3) Deploy specific strategies to address SDOH, (4) Develop partnerships with community organizations to improve health,and (5) Ensure COVID-19 vaccination and communication strategy incorporate health equity. The following activities support work in these areas:

Developed of survey to collect feedback from PHM staff to inform development of operational plans for the Overcoming Health Disparity Strategic priority (*Fig.1*).

- Adopted a framework (*Fig. 2*) to guide health equity efforts.

Established action teams to focus on the following projects:

- Health Equity and SDOH Data – to explore SDOH Data, utilization of SDOH Z Codes by providers, and inventory of internal health assessment utilized to capture SDOH-related needs.
- Health Equity Training – to develop a health equity training program, including an assessment to identify specific training needs.

Engaged with Orange County's Equity in OC initiative — a CDC-funded, community-informed and data-driven initiative to address health inequities and disparities in Orange County by laying the foundation for creating a healthier, more resilient and equitable community.

- Four workgroup participants are currently participating in the Population Health Equity Collectives focused on the Latinx, Black, LGBTQ+ and Older Adults populations. The collectives are tasked with creating a health equity plan, including landscape analysis of the respective populations, defining SDOH-focused areas and outlining strategies and projects.

Supported efforts to promote COVID-19 vaccination, including:

- Tailoring member education on the importance of vaccination.
- Sending targeted text messages to population segments who are at high risk for not getting vaccinated.
- Providing member incentives to ensure health equity across race, ethnicity and socioeconomic status (extended our COVID-19 incentive program until 2023, which far surpasses what other health plans have done).
- Coordinated with the Orange County Health Care Agency and other community partners to plan community-based clinics.

Findings

There is a strong organizational commitment to advance health equity and CalOptima Health is taking unprecedented steps to address health inequities, including:

- Changing the mission and vision to reflect the evolution of the organization and our member population.
- Dedicating one of the five strategic priorities in the strategic plan framework exclusively to overcoming health disparities.
- Approving a Chief Health Equity Officer position to start active recruitment ahead of the DHCS's 2024 contracting requirement.
- Purchasing the NCQA Health Equity Accreditation standards to begin reviewing and exploring the application process ahead of the DHCS' 2026 contracting requirement.
- Contracting with a NCQA consultant to conduct a gap analysis in preparation for Health Equity Accreditation.

Research conducted by the Health Equity Data Action Teams regarding SDOH data found the following:

- Low utilization of SDOH Z-Codes in claims submitted by providers:
  i. 6.70 % of providers are using SDOH Z Codes
  ii. .45% of total claims/encounters include SDOH Z Codes
  iii. 3.14% total members have claims with SDOH Z Codes

No evidence-based, validated SDOH screening tool is used consistently across member-facing departments:

1. 13 known assessments in GuidingCare, of which nine include SDOH-related fields (two known assessments for food insecurity, 10 known assessments for housing)

Research conducted by the Health Equity Training Action Teams found the following:

- CalOptima Health University has more than 350 training modules referencing health equity at the manager level and close to 200 results at the individual contributor level.

1. There are two types of subscriptions, each with access to different content. One of the subscriptions is only available to staff in leadership level positions, thus the difference in access to courses.

Analysis

Based on the five areas prioritized by the workgroup to guide and evaluate their impact, the activities that took place in 2022 demonstrate significant contributions by the workgroup, in some areas more than others.

- There were significant gains in making health equity a strategic priority, developing structure and process to support health equity work, and ensuring COVID-19 vaccination and communication strategy incorporate health equity.
- Under deploying specific strategies to address SDOH, the work was significant in the exploration and research face and recommendations were drafted by the workgroup to develop strategies. This will be an area of focus for 2023.
- Under developing partnerships with community organizations to improve health and equity, the workgroup is exploring potential opportunities (listed below) and will make this an area of focus for 2023.

Barriers

- Work produced by the workgroup is done in addition to current job responsibilities.
- The workgroup is mostly PHM staff and lacks cross-functional expertise from other departments.
- Doing health equity requires dedicated time and resources.
- Staff come from different levels of awareness and building foundational knowledge requires intentionality.
- Data to inform strategy development for SDOH is limited to claim data, which current analysis demonstrated low utilization of SDOH Z Codes in claims submitted by providers.
- No evidence-based, validated SDOH screening tool is used consistently across member-facing departments.

Opportunities for Improvement

a. Engage additional CalOptima Health staff from cross-functional areas to participate in the workgroup.

b. Recognize workgroup participants who have remain engaged in the workgroup.

c. Expediate hiring of Chief Health Equity Officer, reactivate other Equity Initiative workgroups and dedicate a team to work on health equity efforts across the organizations.

d. Incentivize and encourage utilization of SDOH Z Codes among providers.

e. Promote network/provider SDOH screening using evidence-based screening tools (ex: PRAPARE, utilization of SDOH Z Codes).

f. Use the transition to a new care management platform (JIVA) to ask consistent, evidence-based questions across all member-facing departments/programs and link members to resources for social needs using closed-loop referral system (such as FindHelp, Unite Us, etc.).

g. Work with Human Resources to catalog existing health equity training content within CalOptima Health University, curate content to select short videos that can be sent out to staff and/or assigned by managers.

h. Extend CalOptima Health University subscription to eliminate tiers and ensure all materials available at the leadership level are available across all employee levels.

i. Conduct an organization-wide health equity and/or SDOH benchmarking assessment.

j. Administer a survey to inform training needs and opportunities for capacity building.

k. Research best practices, develop training plan and work with vendor management to contract a health equity trainer.

l. Conduct a landscape analysis of community-based organizations and expand partnerships and level of engagement.

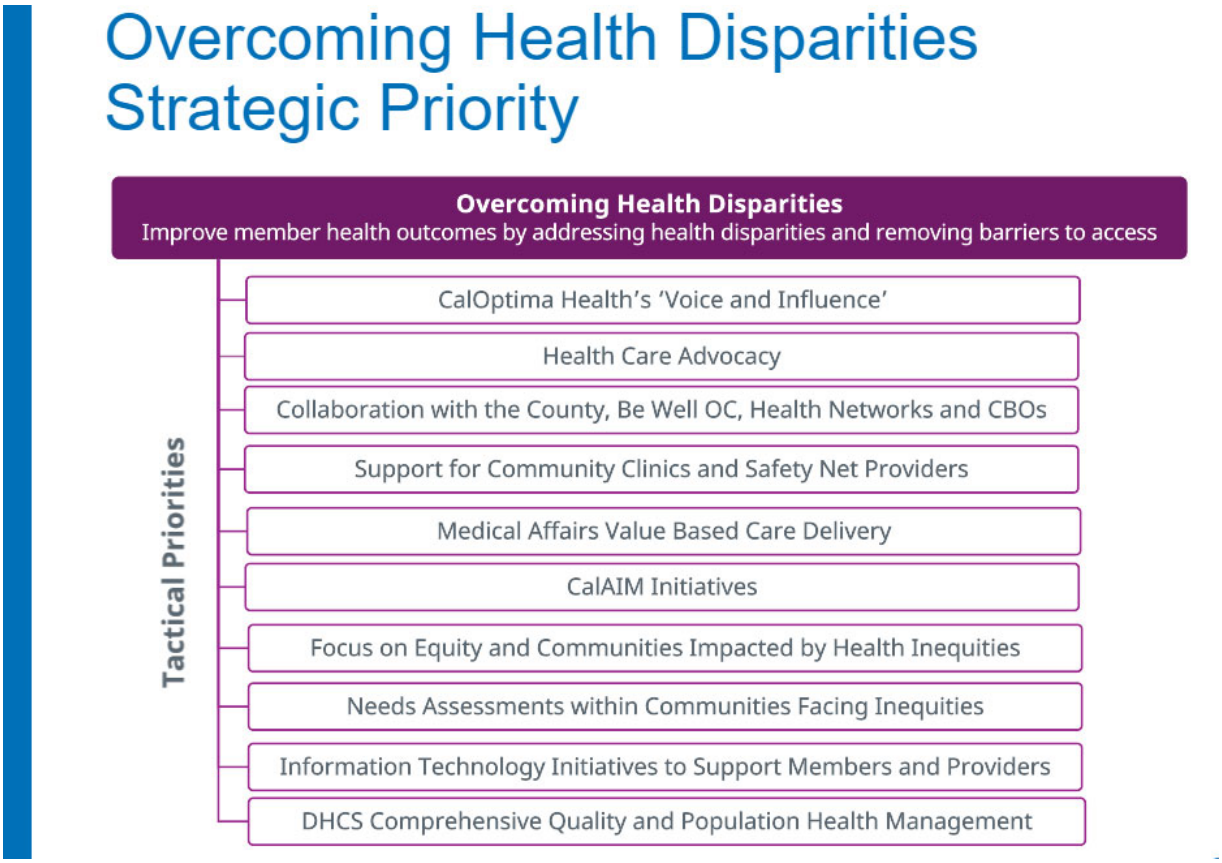


Fig. 1: Overcoming Health Disparities Strategic Priority

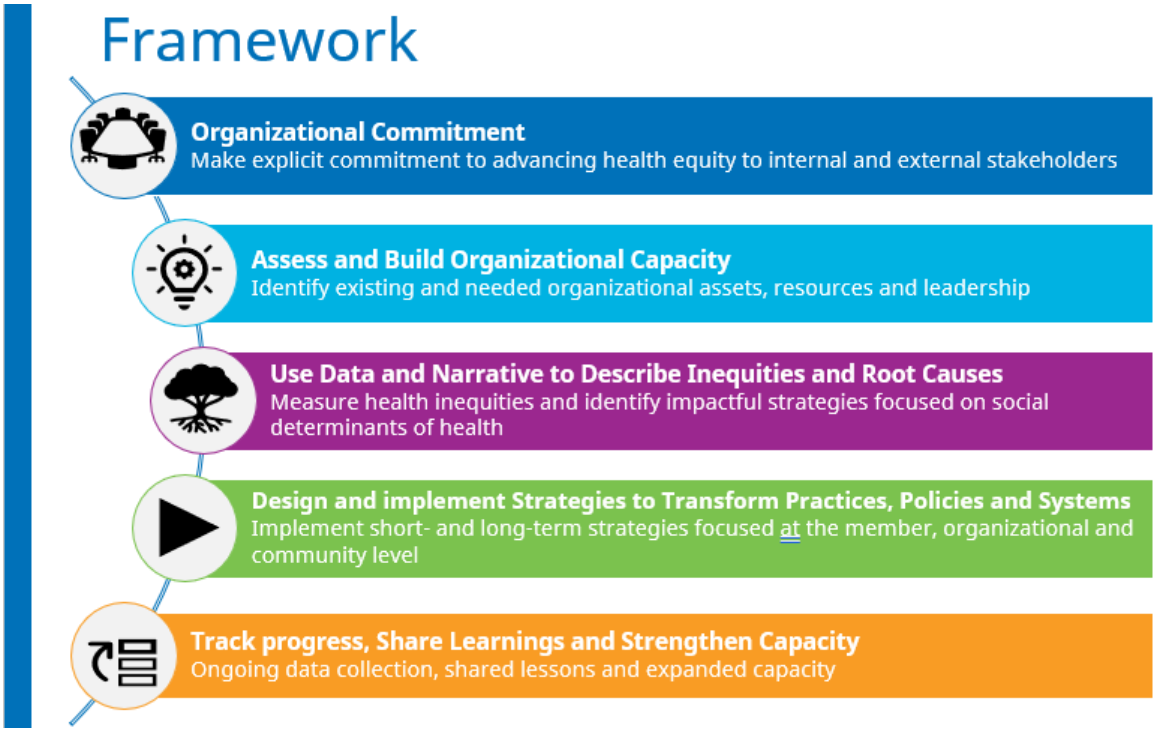


Fig. 2: Health Equity and SDOH Workgroup framework

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms. CalAIM has three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Interventions

a. Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits and discharge delays.

CalOptima Health's implementation of ECM and Community Supports built upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima Health's HHP Community- Based Care Management Entities have transitioned to become ECM providers. This means that CalOptima Health and our delegated health networks have been providing ECM services as ECM providers to eligible populations. Members participating in WPC and/or HHP were automatically transitioned into ECM. These providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

b. Enhanced Care Management

Beginning January 1, 2022, ECM went live for the following populations of focus:

1. Individuals and families experiencing homelessness
2. Adults at risk for avoidable hospital or Emergency Department (ED) utilization
3. Adults with serious mental illness (SMI) or substance use disorder (SUD)
4. Adults with Intellectual or Developmental Disabilities (I/DD)
5. Adults transitioning from incarceration
6. Adult pregnant and postpartum individuals at-risk for adverse perinatal outcomes

Beginning January 1, 2023, the following additional populations of focus will go live:

1. Adults eligible for long-term care
2. Adult nursing facility residents

And then on July 1, 2023, the last population of focus will go live:

1. Children with special conditions: high utilizers, serious emotional disturbance (SED), California Children's Services (CCS), Whole-Child Model (WCM), child welfare and transitioning from incarceration

c. Community Supports

Community Supports services include the 14 captured below. CalOptima Health launched these services on the following dates:

On January 1, 2022, the following services went live:

i. Housing transition navigation services
ii. Housing deposits
iii. Housing tenancy and sustaining services
iv. Recuperative care (medical respite)

On July 1, 2022, the next round of services went live:

i. Short-term post-hospitalization housing
ii. Day habilitation
i. Personal care and homemaker services
ii. Medically tailored meals
iii. Sobering centers

On January 1, 2023, the last of the supports went live: 10) Respite services, 11) Environmental accessibility adaptations (home modifications), 12) Nursing facility transition/diversion to assisted living facilities, 13) Community transition services/nursing facility transition to a home, and 14) Asthma remediation.

d. Building the Provider Network

CalOptima Health has prioritized building a diverse provider network over the past year, ensuring culturally relevant and accessible care. The CalAIM team has engaged in numerous meet and greets, attended service provider meetings, trained providers at any opportunity offered, and taken the time to really get to know providers, the members they serve and how we can best help them meet members' needs. Further, the team has found that engaging providers by touring their facilities, trying their meals and allowing them to share their many accomplishments has built a solid foundation for partnership. Once engaged and interested in partnering, the CalAIM team has served as liaisons to support and assist providers on their journey to becoming a CalOptima Health provider. The team starts by being transparent and educating on the onboarding process, keeping in routine contact, providing updates on their status, responding quickly to inquiries, and holding individualized training sessions. These various efforts have allowed for growth of the provider network. With the launch of services in January, CalOptima Health has 53 providers. While building the provider network, the CalAIM team has seen firsthand that an investment in providers is an investment in CalOptima Health members.

1. Findings

Table A

Community Support	Key Performance Indicator	Total
CalAIM Members	# of unique members in CalAIM	5,065
	# of Community Supports only members	1,045
	# of Community Supports to ECM members	362
Recuperative Care	# of unduplicated members of receiving recuperative care	308
	# of recuperative care days provided	14,684
	Average length of stay	28
Housing Navigation	# of unduplicated members receiving housing navigation services	1,452
Housing Deposits	# of unduplicated members receiving deposits	177
	Average amount spent on each member for housing deposits	$2,192.72

Housing Sustainability	# of unduplicated members receiving Housing Sustainability services	429
Short-Term Post Hospitalization (STPH)	# of members receiving STPH	22
	# of STPH days provided	671
	# of members rolling over from recuperative care	20
	Average length of stay	30
Day Habilitation	# of members receiving Day Habilitation	38
	# of Day Habilitation days provided	82
Medically Tailored Meals	# of members receiving meals	45
	# of children/youth <= 21	1
	# of Adults > 21 and <65	37
	# of Seniors 65+	7
	# of meals served/provided	2,737
	Average number of meals provided	60
Sobering Centers	# of members receiving sobering services	22
Enhanced Care Management	# of members receiving ECM	1,398
	# of members receiving both ECM and Community Supports	524
	# of members in Population of Focus (POF) 1: Individuals and Families Experiencing Homelessness	1,165
	# of members in POF 2: Adult High Utilizers	888
	# of members in POF 3: Adult SMI/SUD	149
	# of members that are children/youth	192
	# of members outreached	4,020
	# of members self-referred	362
	# of members declined ECM services	2,000
	# of discontinued ECM services	613

2. *Table caption: Data demonstrating the growth of ECM and Community Supports benefits.*

Analysis

a. CalAIM has seen considerable growth since launching in January 2022; data as of mid-November demonstrates 5,065 unique members have been served with ECM, Community Supports or both. Table A demonstrates the number of unique members benefitting from each of the nine Community Supports that were available first.

b. Becaue CalAIM only launched in January 2022, there are no findings from the previous year by which to compare.

c. The following objectives in the annual QI plan were met:

- Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022. All HHP members were successfully transitioned to CalAIM ECM without an interruption in service.

- Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022. While objective was not met in Q1 2022, all WPC members were successfully transitioned to CalAIM ECM without an interruption in service in Q2.

- Establish DHCS reporting process was completed in Q3. A DHCS reporting process has been established. ITS leads the data collection and Care Management, LTSS and CalAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up to date.

d. The following objectives in the annual QI plan are in progress:

- Establish oversight strategy for the CalAIM program. The team has begun this effort but has spent more time launching the program and ensuring services are accessible and being delivered. Next year, building out this strategy and implementing it will be priorities for the team.

Barriers

Most objectives have been accomplished for this program. EMC and Community Supports services have been launched, members are being connected to services, and the CalAIM team continues to build out the provider network to adequately serve the members' unique and diverse needs and backgrounds. With so much effort concentrated on launching the program, designing the benefits, engaging providers and ensuring services are accessible, the team has not fully designed the oversight strategy for CalAIM programs. This will be the focus in 2023.

Opportunities for Improvement

CalOptima Health continues to build its CalAIM team. Additional team members will help support the workload to establish and launch the oversight strategy. Furthermore, the team is designing reporting templates to monitor utilization of these benefits. By establishing, reviewing and acting on these reports, the team will continue to evolve the services to best meet member needs.

Homeless Health Initiatives (HHI)

In 2019, CalOptima Health's Board of Directors allocated $100 million toward increasing access to health care and housing support services for unhoused individuals in Orange County. Programs included Clinical Field Teams, Homeless Clinic Access Program and Homeless Response Team among others. DHCS launched the Housing and Homelessness Incentive Program (HHIP) in January 2022. The remaining, unspent funds for HHI, totaling $40.1 million, were then approved by the Board for reallocation to be used as community investments in support of HHIP. Prior to the September reallocation of HHI funds, the Board approved staff's request to proceed with development of a new street medicine program.

Homeless Response Team

1. Interventions

a. The Homeless Response Team (HRT) continued with virtual hours at shelters in the area during the first two quarters. In the third quarter, the HRT began providing in-person shelter outreach. CalOptima Health members were able to connect with a Homeless Response Team Personal Care Coordinator directly. The Personal Care Coordinators assisted members with scheduling PCP appointments, replacing CalOptima Health identification cards, and answering questions about authorizations, transportation, Denti-Cal and CalFresh as well as other services. Members are also often referred to Case Management, Enhanced Care Management and Community Supports as applicable.

b. The Clinical Field Teams (CFTs) provided urgent care services to individuals experiencing homelessness throughout 2022. These urgent care services included wound care, evaluation of physical signs and symptoms, such as cough or pain, and assessments for recuperative care. The CFTs were available six days/week (Monday–Saturday). HRT often coordinates and collaborates with the CFT to mutually support members.

2. Findings

a. Virtual outreach to shelters was expanded in 2022 to include two additional shelters: Huntington Beach Navigation Center and Costa Mesa Shelter. The HRT continued virtual outreach to Yale Navigation Center, and in the third quarter, began providing in-person assistance there. With the observed benefits to CalOptima Health members experiencing homelessness, expansion of in-person outreach is continuously being explored with a plan to add three additional shelters in the fourth quarter.

b. The CFT program dispatches contract community health centers to provide urgent care, on-call services wherever the individual is located — More than 99% of all visits for care are completed face-to-face. From January 1, 2022, through November 30, 2022, HRT received 421 calls and dispatched the CFTs a total of 404 times. Of those calls dispatched, 375 individuals were treated, and 289 (77%) were CalOptima Health members. The CFTs made 81 referrals to Recuperative Care. Orange County's Outreach & Engagement (O&E) and the Mental Health Association (MHA) are the top two referring agencies, producing 76% of all referrals made to the HRT dispatch line.

3. Analysis

a. The HRT met its objectives of expanding its virtual shelter outreach in quarters one and two and beginning in-person outreach in quarter three.

b. When comparing 2021 data to 2022, the CFT program saw increases across the board on nearly all key process measures except for referrals to Recuperative Care, which decreased. The percentage of time where visits were conducted face-to-face remained consistent at over 99%. A comparison of the data can be found in the table below:

Process Measure	2021	2022	% Change*
Calls Received by HRT	355	421	19%
Total Number of Dispatches	339	404	19%
Total Number of Individuals Treated	305	375	23%

Members Treated	241	289	20%
Referrals to Recuperative Care	91	81	-12%

***Rounded up to the nearest whole number**

4. Barriers

The main barrier to expanding the virtual outreach in quarters one and two were the technical limitations of the shelters to provide phone and video access for members. Physical space at the shelters was available as they have been receptive and open to HRT's presence.

5. Opportunities for Improvement

The HRT will continue to increase its presence in the community by providing in-person assistance to members at high-volume shelters.

Street Medicine Pilot Program

The goal of street medicine is to provide health care services, both preventive and urgent, to unhoused members where they are located. The selected providers for the Street Medicine Pilot Program will be contracted before the end of 2022. The preliminary plan is to launch the program in early 2023.

1. Interventions

a. A Request for Qualifications (RFQu) was launched in July 2022 to solicit proposals from providers to participate in the inaugural Street Medicine Pilot Program. Through that process, two providers were selected to participate in and support the launch of an innovative two-pronged street outreach and medicine program that targets both unsheltered and sheltered individuals in Orange County.

b. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well, other related county agencies, and homeless service providers. The planning phase is anticipated to begin in December 2022, with actual services launching in early 2023.

2. Findings

There are no findings from the previous year as this is a pilot program.

3. Analysis

CalOptima Health staff met their objectives of developing a scope of work, administering an RFQu, and selecting two providers to begin providing services in Garden Grove. The remaining objective is to finalize the Street Medicine scope of work with selected providers, develop payment terms and execute contracts.

4. Barriers

a. CalOptima Health staff do not anticipate hitting any barriers to achieving the remaining objectives, as noted on item 3a above. Moreover, while it was established that the program would only launch in Garden Grove, staff recognize the need to scale services throughout Orange County, though a timeline for scaling the pilot program is still to be determined.

5. Opportunities for Improvement

a. CalOptima Health staff will continue collaboration with the two providers who will be contracted to provide services through this pilot program to build out a plan for expanding service reach throughout the county in a timely manner.

Housing and Homelessness Incentive Program

1. Interventions

a. The CalAIM team implemented the Housing and Homelessness Incentive Program (HHIP), in coordination with the local continuum of care (CoC) and other key stakeholders, to increase capacity and develop partnerships among homeless services providers — serving a more active role in reducing and preventing homelessness in Orange County. The team implemented the Investment Plan to meet specific measures around increased data integration, access to culturally appropriate care, and building up the infrastructure to support more complete and comprehensive systems.

2. Findings

a. HHIP began in January 2022, thus, there are no points for comparison to the previous year. The first incentive payment of $4.1 million for completion of the Local Homelessness Plan (LHP) was transmitted to CalOptima Health in October 2022.

b. Staff initiated community investment recommendations to CalOptima Health Board of Directors. Staff began the process to execute identified contracts and/or launch opportunities for a competitive bidding process for certain activities. These activities were funded by HHI funds ($40.1 million) that the Board approved for reallocation.

c. There are no findings from the previous year as the program launched January 1, 2022.

3. Analysis

a. Staff met the initial objectives for HHIP by submitting a LHP and Investment Plan (IP) to DHCS by the specified deadlines (June 30, 2022, and September 30, 2022, respectively).

b. Staff achieved their objective to involve/inform the community at large to the greatest extent possible in Q3 of 2022. This includes but is not limited to:

i. Convening a public listening session in August 2022.

ii. Seeking approval and/or feedback of staff recommendations for the IP at CalOptima Health's Board of Directors and various Advisory Committee meetings.

iii. Presented the draft IP to Orange County's CoC and obtained a signed letter of support (a key elements for submission of the IP to DHCS).

4. Barriers

a. DHCS requirements for obtaining full points for achieving HHIP measures continue to cause concern.

b. Administrative lift and timing related to development and implementation of both contracts and competitive funding opportunities.

c. Overlap with other funding can potentially lead to duplication of services. There is also a significant amount of funding that needs to be disbursed into the community, and it needs to be done in a fair, consistent and meaningful way.

5. Opportunities for Improvement

a. Continue to meet with other HHIP participating managed care plans and communicate with DHCS about concerns, while also proposing potential alternatives to ensure plans can maximize incentive funds earned.

b. Collaborate with key internal and external stakeholders to effectively navigate any administrative barriers, ensuring processes are as streamlined as possible.

c. Map out the county homelessness service continuum and implement appropriate and impactful strategies to minimize systemic redundancy. Consider best practices to ensure the greatest return on investment without sacrificing service quality.

Quality Withhold for OneCare Connect (OCC)

To better align quality with cost of care, DHCS and CMS have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A and B capitation to health plans. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Fourand Five (calendar years 2017–19). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received from CMS and DHCS.

The CalOptima Health Pay for Value (P4V) team monitors the OCC withhold measures on a quarterly basis.

Quality withhold payments are determined based on the percentage of all withhold measures, including CMS core and state-specific measures, each managed care plan (MCP) meets. All measures are weighted equally, with no distinction made between measures that earned a "met" designation by meeting the benchmark and measures that earned a "met" designation by meeting the gap closure target. In general, benchmarks for CMS core measures are established using national data such that all MCPs across demonstrations are held to a consistent level of performance. For state-specific measures, benchmarks are developed by states using state-specific data, as well as national data when available/appropriate

For MY2022, CalOptima Health has passed 6 of 10 as of September 30, 2022. The four measures that we will be closely monitoring for the last quarter include:

1. Controlling Blood Pressure
2. Encounter Data Submission
3. Follow-up After Hospitalization 30 days
4. Interaction with Care Team

DY8 (CY2022) Preliminary Analysis

Quality Withhold Analysis – 4% Withhold	
Quarter 3 Results	
Total number of measures	10
Total number of measures passed	6
Percent of measures passed	60%
Percent of withhold plan receives	75%

Quality Analytics Program Updates (Health Network Quality Rating, 1MCAS, P4V, Data Mining/Bridge Efforts)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. CalOptima Health currently has P4V programs for Medi-Cal and OCC. All CalOptima Health networks (HNs), including the directly managed CalOptima Health Community Network (CCN), and primary care providers (PCPs) are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

[1] MCAS = Managed Care Accountability Set

a. Recognize and reward HNs and their physicians for demonstrating quality performance;

b. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and

c. Provide industry benchmarks and data-driven feedback to HNs and physicians on their quality improvement efforts.

A new methodology for the Medi-Cal P4V Program was adopted for measurement year (MY) 2020–21, aiming for greater transparency, consistency and administrative simplification. This new HN Quality Rating (HNQR) methodology aligns with changes to measures for CalOptima Health's National Committee for Quality Assurance (NCQA) Accreditation status, CMS Star Rating status, DHCS (MCAS) and overall NCQA Health Plan Rating. Having a standard Quality Rating Methodology provides CalOptima Health with one reliable methodology to establish an overall quality rating score for each Health Network. The quality rating score may be used for future P4V payment methodology, incorporated into the new Auto Assignment policy, or other future programs to improve health care quality for CalOptima Health members.

a. Each HN quality rating score will be calculated annually.

b. The HN quality rating score will be derived from the most recently available audited, plan-level HEDIS results, which are based on the administrative methodology. For measures that have a hybrid method option, the additional percentage from medical records collection (i.e., the difference between CalOptima's hybrid and administrative result) will be added to each HN's results.

c. HN-level Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) results will be used for member experience scoring.

d. NCQA Quality Compass National Medicaid percentiles will be used as benchmarks.

e. All Managed Care Accountability Set (MCAS) measures that are required for Minimum Performance Level (MPL) by DHCS are used.

f. CAHPS measures are used for member experience.

g. Measures with small denominators (HEDIS < 30; CAHPS < 100) are not used in the score calculation.

The new methodology was approved by the CalOptima Health Board of Directors on February 6, 2020. The Board of Directors also approved an increase in the per member per month (PMPM) incentive for CCN providers and HNs from $2.00 PMPM to $5.00 PMPM.

Development of the Pay-for-Value (P4V) OneCare Program for MY2023

CalOptima Health's P4V team compiled a set of Medicare Part C, Part D and Member Experience measures as proposed metrics for the measurement year (MY) 2023 OneCare P4V program, which was approved by the CalOptima Health Board of Directors.

The OneCare measures for MY2023 are as follows:

a. Part C Measures: Breast Cancer Screening, Colorectal Cancer Screening, Diabetes Care – Eye Exam, Diabetes Care – Hemoglobin A1c Control, and Controlling Blood Pressure.

b. Controlling Blood Pressure Part D Measures: Medication Adherence for Diabetes, Medication Adherence for Hypertension, Medication Adherence for Cholesterol and Statin Use in Persons with Diabetes

c. Member Experience Measures: Care Coordination, Getting Care Quickly and Getting Needed Care

Development of Hospital Quality Program

In December 2022, the CalOptima Health Board approved a new Hospital Quality Program for CalOptima Health contracted hospitals for calendar year 2023 to 2027. The goal of the program is to improve quality of care to our members through increased patient safety efforts and performance-driven processes. Hospitals holding a direct Medi-Cal contract with CalOptima Health are eligible to participate in the Hospital Quality Program. The Hospital Quality Program will establish a process to measure performance and incentivize contracted hospitals to deliver quality care. The program will:

- Leverage publicly available hospital data and performance listed on CMS Care Compare and the Leapfrog Group to minimize hospital burden

- Require contracted hospital participation in CMS Care Compare (for hospital inpatient, hospital outpatient, PPS-exempt cancer, or inpatient psychiatric measures) and/or Leapfrog Group Hospital Rating
    - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital Rating.
    - Contracted hospitals not listed on either CMS Care Compare or Leapfrog will not qualify for incentive payments.
- Allocate a maximum of $30 million per year for five years
- Hospital incentive payments distribution
    - Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

Measurement Area	Data Source	Percent of Incentive Pool	Performance Range	Incentive
Quality	CMS Care Compare or Leapfrog Hospital Rating	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Patient Experience	CMS Care Compare or Leapfrog Hospital Rating	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Hospital Safety	Leapfrog Hospital Safety Grade	20%	Grade A Grade B Grade C Grade D or F	100% of incentive 75% of incentive 50% of incentive 0% of incentive

CalOptima Health recognizes that hospitals may not currently participate in these public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During this time, CalOptima Health will provide hospital reporting incentive payments in an amount of $150,000 per eligible hospital per calendar year.

Performance Improvement Projects (PIP)

The following is a summary of the PIPs for all lines of business.

Health Equity Performance Improvement Project (PIP) — Medi-Cal

DHCS requires that Medi-Cal MCPs conduct a PIP that targets health care disparity that is related to a Managed Care Accountability Set (MCAS) metric on which the MCP is performing below the minimum performance level. Particular focus may be on a disparity that may have been exacerbated by COVID-19 pandemic.

CalOptima Health's PIP focused on Breast Cancer Screening (BCS) based on a decreased breast cancer screening rate from 63.4% in HEDIS MY2019 to 59.52% in HEDIS MY2020. In addition, of the approximately 33,774 female Medi-Cal members ages 50–74 identified, 14,519 did not have a BCS between 1/1/2020 and 12/31/2020. When we categorize members based on written language, we see that Korean and Chinese have the lowest rate of BCS of 58% and 45% respectively, and Vietnamese has the highest rate 67%. Because of this disparity, CalOptima Health chose to focus the PIP on female members ages 50–74 who have their written language identified as Korean and Chinese. Interventions focused on increasing culturally appropriate outreach and education to the Korean and Chinese Medi-Cal membership population about the importance of screening and the no-cost screening benefit for CalOptima Health members.

Intervention

Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Health Medi-Cal Members (March 1, 2020–December 31, 2022)

a. Per the HEDIS Technical Specification, the description of the BCS measure is: The percentage of women ages 50–74 who had a mammogram to screen for breast cancer.

b. CalOptima Health estimates that there are 1,272 Medi-Cal members ages 50–74 who have their written language identified as Korean and Chinese who are eligible to complete a mammogram to screen for breast cancer.

i. **Goal**: By 12/31/2022, increase the percentage of breast cancer screening among Korean and Chinese Medi-Cal member ages 50–74 from 53.62% to 57.63%

ii. **Target Population**: Total number of Korean and Chinese CalOptima Health Med-Cal members ages 50-–74 as of December 31.

iii. **Intervention**: Mobile Mammography Community Event Clinic. Members ages 50–74 were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event.

iv. **Activity**: CalOptima Health partnered with Provider Office A and a mobile mammography vendor for multiple mobile mammography community events to eligible CalOptima Health members held once per quarter.

c. Two additional events were held August 15 and October 24, 2022.

Findings

d. Table 1 shows the results for Cycle 1 mobile mammography community event intervention held in February 2022, and Cycle 2 held in May 2022.

Table 1: Health Equity PIP Cycle 1 and 2 Results

Testing Period	Numerator	Denominator	Percentage
1/12/2022–2/2/2022	4	71	5.63%
2/3/2022–5/17/2022	10	112	8.93%

Numerator: Number of Korean and Chinese CCN Medi-Cal members ages 50-74 for Provider Office A who were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event. Denominator: Total number of Korean and Chinese CCN Medi-Cal members ages 50–74 for Provider Office A who are eligible to complete a mammogram to screen for breast cancer and in the mailing for the mobile mammography community event letter.

Analysis

Provider Office A became a new site for mobile mammography community event. This gave members access to breast cancer screenings in a familiar environment. Provider office A staff was available to assist members with check-in for their appointment and completing necessary paperwork in the member's preferred language. Provider Office A had previously stated that members had a language barrier when visiting a radiography facility.

In January 2022, of the 71 members who were mailed the mobile mammography event letter, 4 members completed a mammogram at the mobile mammography event held on February 2022. The percentage of eligible Korean and Chinese CalOptima Health CalOptima Community Network (CCN) Medi-Cal members ages 50–74 for Provider Office A who were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event was 5.63% (4/71). In April 2022, of the 112 members who were mailed the mobile mammography event letter, 10 members completed a mammogram at the mobile mammography event held on May 2022. The percentage of eligible Korean and Chinese CalOptima Health CCN Medi-Cal members ages 50–74 for Provider Office A who were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event was 8.93% (10/112).

Barriers

Two barriers that were being addressed by hosting a mobile mammography event at Provider Office A were language barrier and an access barrier. Provider Office A discussed the challenges that are faced by their members when going to the radiology facility. During the events, Provider Office A staff was available to provide interpretation services to the members. Hosting the mobile mammography event at the clinic, the members were familiar with the location.

Additional Barriers Included:

a. The data that was used for the mailing was not up to date for Korean and Chinese members who were due for breast cancer screening for 2022. CalOptima Health was only able to identify 71 current members who were due for breast cancer screening.

b. The mobile mammography vendor required a minimum of 25 scheduled appointments for the event to occur. The vendor scheduled members under their Every Women Counts (EWC) outreach database to fill open time slots to ensure the required capacity.

c. Only 10 members from the mailing of the 112 that were identified attended the event. The additional members were scheduled via Provider Office A health navigator telephonic outreach.

Opportunities for Improvement

a. For the proceeding events, current data of Korean and Chinese members due for breast cancer screening will be obtained for the event mailing.

b. Only members who are assigned to Provider Office A will be scheduled.

c. Part of intervention step was to share the outreach mailing list with the Provider Office A health navigator. CalOptima Health will request that the Health Navigator conduct follow-up calls after mailing to Korean and Chinese members identified on the mailing list.

d. In MY2023, the PIP will expand by adding a mobile mammography community event to Provider Office A new site location to target more of the Chinese CalOptima Health CCN Medi-Cal members.

2020–22 Well-Child Visits in the First 30 Months of Life (W30-6+) Performance Improvement Project (PIP)

DHCS requires that Medi-Cal MCPs conduct a PIP that targets a child and adolescent health metric related to the Managed Cared Accountability Set (MCAS) on which the MCP performance is below the minimum performance level and has been exacerbated by COVID-19 pandemic.

CalOptima Health's overall Well-Child Visits in the First 15 Months of Life (W15) HEDIS® rate, which has been revised to Well-Child Visits in the First 30 Months of Life (W30-6+) HEDIS® measure, has declined over the past six years while the National Quality Compass benchmarks continue to grow. The rates have been trending downward from 70.37% (2014) to 51.09 % (2018). The rates continued to decline with the Medicaid expansion in 2014 where CalOptima Health increased its membership by 234,000 members.

Well-child visits are the foundation of pediatric health and wellness. At these visits, medical providers provide immunizations, assess the child's growth and development, and provide anticipatory guidance for parents. The Bright Futures/American Academy of Pediatrics (AAP) developed a periodicity schedule for preventative pediatric health care best practices from infancy to adolescence. These best practices are highlighted in the HEDIS® Well-Child Visits in the First 30 Months of Life (W30) measure which requires six or more well-child visits in the first 15 months of life, and additionally two or more well-child visits between 15–30 months of life. These visits must be completed by a PCP.

Based on decreasing performance and the importance of well-child visits, CalOptima Health initiated a well-child PIP in 2020 and continued the PIP through 2022.

Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Health Medi-Cal members with Provider Office A (June 1, 2021–December 31, 2021)

a. Per the HEDIS Technical Specifications, the description of the W30-6+ measure is the percentage of members who had the following number of well-child visits with a PCP during the last 15 months during the measurement year: six or more well-child visits.

b. CalOptima Health established a data sharing procedure between the MCO and the provider office to identify members due for outreach. The W30-6+ target list was shared with the provider office on a quarterly basis. The provider office had approximately 60 days to reconcile the target list with their internal records and provide the list back to CalOptima Health. The provider office aimed to outreach to members who had not completed their visits. The intervention was implemented in late October 2021 and ran through the end of December 2022.

    i. **Goal:** By 12/31/2022, use key driver diagram interventions to increase the percentage of well-care visits among Medi-Cal members turning 15 months old for Provider Office A, from 39.47% to 44.96%.

    ii. **Target Population:** Medi-Cal members assigned to Provider Office A, who turn 15 months old during the measurement year.

    iii. **Intervention:** CalOptima Health established a data sharing procedure between MCO and the provider office to identify members due for outreach. The W30-6+ target list was shared with the provider office on a quarterly basis. The provider office had approximately 60 days to reconcile the target list with their internal records and provide the list back to CalOptima Health. The provider office aimed to outreach to members who were due for their visit. The intervention was implemented in late October 2021 and ran through the end of December 2022.

Findings

Table 1: W30 PIP Cycle 1–3 Outcomes

Outcomes	W30 PIP Intervention Cycles			
	Cycle 1	*Cycle 2*	*Cycle 3*	*Cycle 4*
Intervention period	10/2021–12/2021	04/2022–06/2022	07/2022–09/2022	10/2022–12/2022
Status	Completed	Completed	Completed	In Progress
Denominator	467	487	672	672
Numerator negative	319	435	588	384
Data reconciliation completion rate	100%	100%	100%	N/A
Number of members found to have completed their well-child visits (6+)	153	176	283	N/A
Administrative data variance rate	47.96%	40.46%	48.13%	N/A

Denominator is defined as the provider office's member population who meet the W30 HEDIS specifications. Numerator negative is defined as the number of members who have not completed 6+ well-child visits. Data reconciliation rate is defined as number of records in the target list shared reconciled with provider office's electronic medical records. Administrative data variance rate is defined as the number of member records found to be inaccurate as a result of the target list reconciliation intervention.

Analysis

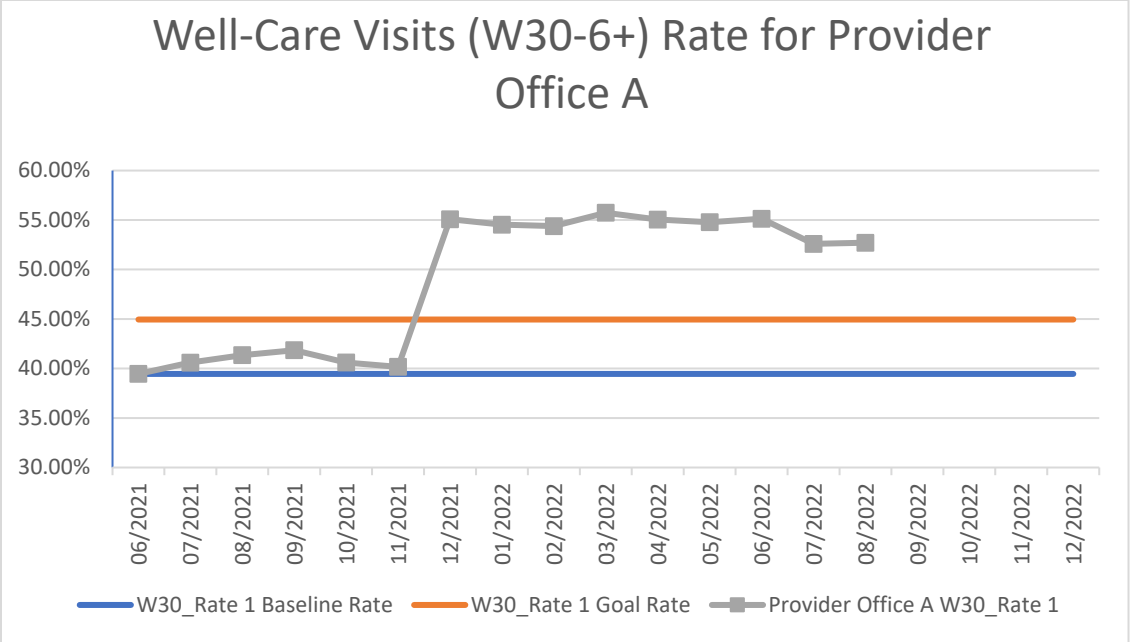
a. Cycles 1–3 findings indicate there is a data gap between services rendered and what is captured through claims and encounter data. On average, 45.52% of the members who were indicated as missing well-child visits were found to have completed 6 or more well-child visits.

b. CalOptima Health was able to establish a data sharing procedure with Provider Office A to send their W30-6+ target list on a quarterly basis.

c. Provider Office A was able to reconcile their target list with their internal records for Cycles 1–3. The target list has allowed the office to readily identify which members fell into the W30-6+ denominator and close gaps by outreaching to members who have not yet completed their visits and submitting supplemental data for services rendered.

d. The intervention period is in progress, but as shown in Figure 1, the provider office W30-6+ rate, based on a 12-month rolling methodology, to evaluate intervention impact, demonstrates that they have surpassed the goal rate of 44.96%. As of December 2021, the office has shown a steady trend between 54.38%–55.73%. The next steps are to continue to monitor their W30-6+ rate to see if the performance is maintained through the end of 2022.

Figure 1: The Percentage of Well-Care Visits for Children in Their First 30 Months of Life (W30-6+) for CalOptima Health Medi-Cal Members with Provider Office A PIP Control Chart



Provider Office A Well-Child visits in the First 30 Months of Life-First 15 (W30-6+) rate was established using a 12-month rolling methodology and removes continuous enrollment criteria. The W30-6+ baseline rate is: 39.47%, goal rate: 44.96%. Intervention was implemented late October 2021 and will continue through December 2022.

Barriers

- CalOptima Health Prospective Rates Report do not capture all the services rendered by a provider office for well-child visits. Each cycle showed a discrepancy between what is captured through claims and encounters data and the information found in the provider office's electronic health record system.
- Provider offices who are contracted with multiple health networks must access different platforms and files to identify their true W30-6+ denominator.
- Not all provider offices are aware of which well-child visits are captured or not captured by the MCP.
- Staff turnover in the provider offices creates a gap in the continuous intervention process.
- Members are unable to schedule future well-child visit appointment(s) due to scheduling system limitations. Schedules are not open more than 2–3 months out from current date.
- Members are unable to attend well-child visits because of scheduling conflicts related to work and provider office hour availability.
- Members are unaware of the importance of well-child visits and are unaware of the number of visits recommended in the first few years of life.

- Transportation and ease of accessibility is a barrier for members to attend their well-child visits. Members are not aware of CalOptima Health's Medi-Cal transportation benefit. Some parents prefer a location closer to home (e.g., community health event) rather than their assigned PCP office.

Opportunities for Improvement

a. For future collaborations with provider offices, CalOptima Health will consider providing the member population specifications to the office to identify their own target list for more accurate information.

b. We will consider providing one singular opportunity gap report that includes all members assigned to the provider office which will include the date of service for the various well-child visits needed to meet HEDIS measure, regardless of health network.

c. CalOptima Health will work with provider offices to proactively identify and outreach to newborn members versus waiting until the measurement year when the members turn 15 months to start interventions. This action will help to foster well-child visits following the Bright Futures Periodicity Table visits in a timely fashion.

d. We will collaborate with the provider offices to understand their challenges, successes and current process with regard to well-child visits. We will develop a best practice guide for providers to better operationalize and close the gaps in ensuring timely well-child visits.

e. CalOptima Health will increase the telephonic call campaigns from an annual to a quarterly campaign to catch members before they age out of the measure. This campaign will allow us to remind parents or guardians to schedule their child's next well-child visit and other preventative care (e.g., vaccinations, blood lead test).

Quality Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP) for all lines of business.

COVID-19 Quality Improvement Plan (COVID-19 QIP)

DHCS required all MCPs to submit a COVID-19 Quality Improvement Plan (COVID-19 QIP). The initial submission included three strategies related to the Managed Care Accountability Set (MCAS) measure domains, one of which must address the behavioral health domain. The three domains CalOptima Health chose to focus on were the behavioral health domain, women's health, and child and adolescent health. The initial COVID-19 QIP submissions were due to DHCS on September 31, 2021, and the six-month progress submission was due to DHCS on March 31, 2022.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

CalOptima Health's program assesses the percentage of members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Members with severe mental illness who use antipsychotics are at increased risk of diabetes. In the United States, diabetes is among one of the leading causes of death. Lack of care for individuals with diabetes who use antipsychotic medications can lead to deteriorating health and death. Screening and monitoring of these conditions are important.

Interventions

a. The BHI Quality Team worked with Quality Analytics to develop a report to identify members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and did not have a diabetes screening test.

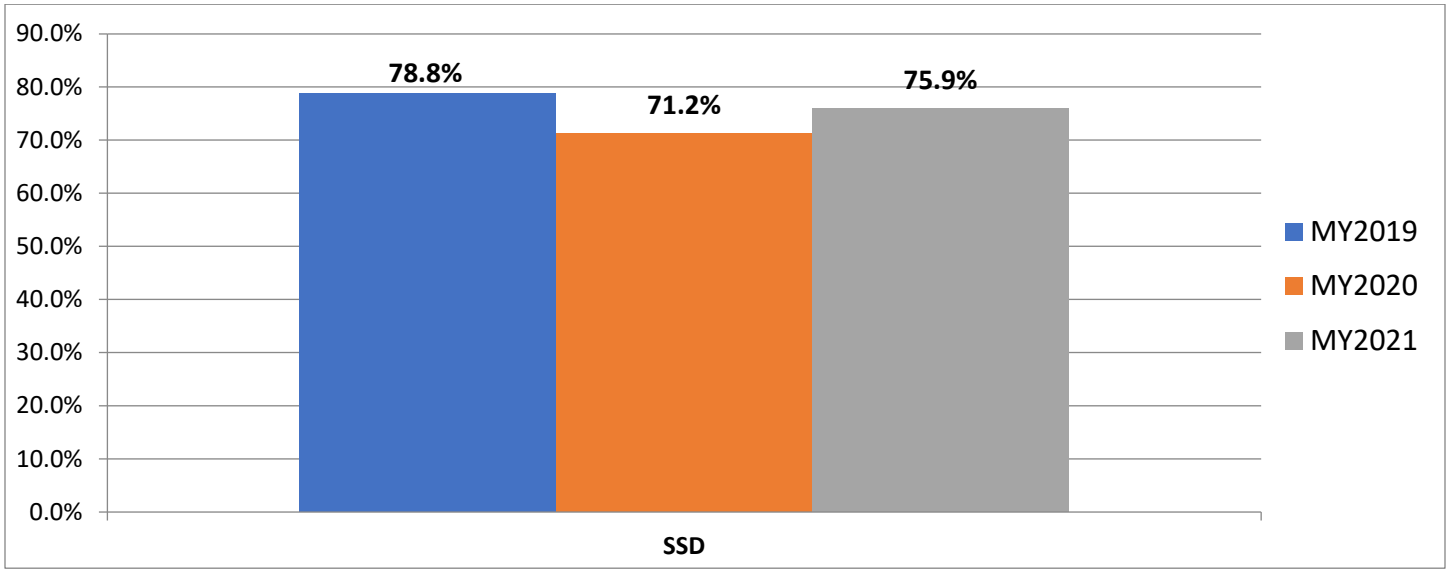
b. In 2021, BHI Quality Team conducted provider outreach targeted to the top 50 prescribing providers of antipsychotic medications in the CalOptima Health network:

    i. Provider offices were contacted telephonically to confirm that provider was still practicing at that location and confirm the provider's fax number is accurate to protect patient privacy in adherence with HIPAA regulations.

    ii. A letter was sent to prescribing providers. The letter contained a comprehensive list of members with the name of the member's PCP, the PCP contact information and an SSD provider educational tool tip sheet, which indicates industry best practices.

Below are the findings for the Measurement Year 2021

Graph A



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications (SSD)	74.94%	78.90%	82.53%	73.69%	HPR

Analysis

a. In 2021, CalOptima Health met the HEDIS goal of 73.69% for the SSD measure going slightly higher by 2.21%. This was a slight increase from the final rate for MY 2020 (71.2%). The rates indicate a slight improvement in the number of members completing a diabetes screening for MY 2021. With the interventions being implemented at the end of the year we anticipate seeing a decrease of members needing a diabetic screening test in the upcoming measurement year 2022.

Barriers

a. The BHI department came across some barriers while completing interventions related to obtaining the contact information for the prescribing providers such as phone numbers, fax numbers, address and providers no longer practicing. This was due to inaccurate provider information within the system. Providers may forget to update their information. Providers are also being reminded of the need to update information during outreach efforts.

b. Prescribing provider offices have shared some of the barriers they experience, such as patients do not always visit their PCP and a lack of transportation.

c. Due to the impact of the pandemic, individuals may have been less likely to attend routine or follow-up appointments and complete health services recommended by their providers.

Opportunities for Improvement

a. CalOptima Health's BHI department has chosen to work on improving the number of members completing a blood glucose or HbA1c test that have a diagnosis of schizophrenia and were dispensed an antipsychotic medication. Discussions on various opportunities are being explored within the Behavioral Health Quality Improvement (BHQI) Workgroup such as:

- Continue to identify members in need of a diabetes screening test, conducting outreach to help raise awareness to the prescribing providers of the need to have members get a blood glucose or an HbA1c test.

- Possible collaboration with county behavioral health. Given the severity of the diagnoses included in the HEDIS measure, it is believed that a number of members may be receiving antipsychotic medications from one of the county clinic-based providers. This may also assist in identifying providers listed as prescribers who are not in the CalOptima Health network.

Women's Health Strategy

a. A hybrid HEDIS and MCAS measure, Cervical Cancer Screening (CCS), examines the percentage of women age 21–64 who received one or more screening tests for cervical cancer during or within the three years prior to the measurement year, or five years for women ages 30–64 with Human Papilloma Virus (HPV) co-testing.

b. The goal of the intervention is to increase the number of Medi-Cal members age 21–64 years of age who were screened for cervical cancer. The intervention will test if member outreach reminders via letter and/or phone call increase CCS rates among eligible CalOptima Health members. The focus is on Medi-Cal members age 21–64 assigned to a specific HN and selected provider office sites. The member outreach modality was chosen by each provider office site based on staffing and resources.

   i. **Goal 1:** By the end of March 2022, an outreach attempt to CalOptima Health members for the completing of the cervical cancer screening will be performed for at least 90% of the target list at the selected HN provider offices. If goal 1 was met, the provider office staff received a predetermined incentive based on the count of the target outreach (Table 2).

   ii. **Target Population:** Medi-Cal members ages 21–64 who are due to complete the cervical cancer screening.

   iii. **Interventions:** CalOptima Health, in collaboration with the contracted HN, identified provider offices that have a high volume of CalOptima Health Medi-Cal members who are due for CCS and are performing low for the measure. Five of the HN provider offices agreed to participate in the intervention. Combined, the CCS denominator of members was 5,035, with a target outreach population of 2,671 members.

Findings (6-month progress)

a. Women's Health Strategy 2

   a. Provider Office 1: There were 1,347 members eligible to complete their cervical cancer screening. Staff chose to do telephonic outreach as the outreach method. A total number of 576 members were outreached to by telephone. The result for this intervention indicated that 42.76% of members on the target list had been contacted, and, therefore, the [2]SMART AIM goal 1 was not reached (Table 1). The provider office did not receive the staff incentive (Table 2).

   b. Provider Office 2: There were 494 members eligible to complete cervical cancer screening. Staff chose to do telephone outreach followed by member mailing as their outreach methodologies. The total number of members who were contacted were 494. The result for this intervention indicated that 100.00% of members on the target list had been contacted, therefore, the SMART AIM goal 1 was reached (Table 1). Provider office staff received the provider office staff incentive (Table 2).

   c. Provider Office 3: There were 331 members eligible to complete cervical cancer screening. Staff chose to do telephone outreach as their outreach method. The total number of members that were outreached was 86. The result for this intervention indicated that 25.98% of members on the target list had been contacted. The SMART AIM goal 1 was not reached (Table 1). The provider office staff did not receive provider office staff incentive (Table 2).

[2] SMART - Specific, Measurable, Attainable, Relevant, Time-bound

Table 1: Cycle 1 Provider Office Cervical Cancer Screening Member Outreach

Provider Office	*Count of Member on Target List*	*SMART AIM Goal 1: 90% of Target List*	*Cycle 1 Count of Member Outreach*	*Outreach Rate*	*Cycle 1 Goal Met*
Provider Office 1	1,347	1,212	576	42.76%	No
Provider Office 2	494	445	494	100.00%	Yes
Provider Office 3	331	298	86	25.98%	No
Total	2,172	1,955	1,156	53.22%	No

Women's Health Strategy Results/Progress member outreach at 6 months

Table 2: Provider Office Staff Incentive for Cycle 1

Provider Office	*Gift Card Amount*	*Gift Card Quantity*	*Monthly Total*	*Frequency*	*Total per office for the cycle*
Provider Office 1	$75.00	15	$1,125.00	1	$1,125.00
Provider Office 2	$75.00	5	$375.00	1	$375.00
Provider Office 3	$75.00	2	$150.00	1	$150.00

Table caption: Women's Health Strategy 2 cycle 1 provider office staff incentive by provider office

a. Table 3 shows the breakdown for all 135 members who were scheduled by the provider offices. The breakdown was as follows: provider office 1 had 126 members scheduled, provider Office 2 had three members scheduled, and provider office 3 had six members scheduled. Appointments scheduled were outside of the cycle 1 timeframe. During the cycle 2, the focus will be on the number of completed cervical cancer screenings from those members who were contacted during cycle 1.

b. Member outreach was able to identify eight members who had a hysterectomy and therefore will be excluded for the cervical cancer screening measure.

c. During the member outreach, provider staff were able to schedule appointments for 135 members for cervical cancer screening; three members were referred to a gynecologist for cervical cancer screening (Table 3).

d. The provider office staff identified 13 members who had cervical cancer screening completed elsewhere. The provider office staff will follow-up on closing care gaps by obtaining the medical records for these members.

e. There were 76 members who were contacted who requested call-back at a later date. The provider office staff will follow-up with these members (Table 3).

Table 3: Cycle 1 Provider Office Cervical Cancer Screening Member Outreach Outcomes

Provider Office	*Member Scheduled*	*Referral Created*	*Member Requested a call back*
Provider Office 1	126	1	71
Provider Office 2	3	0	0
Provider Office 3	6	2	5
Total	135	3	76

Table caption: Women's Health Strategy 2 outcomes in cycle 1. Member was schedule for appointment, referral created to see specialist, or member requested call back at a later date.

Analysis

At the initiation of this intervention, five HN provider offices agreed to participate in the intervention. Only three provider offices continued their participation after 6 months. Two provider offices did not initiate outreach during the cycle 1 period due to the lack of staff resources. Table 1 above shows the results at the end of cycle 1 for the three provider offices that conducted member outreach efforts. The total number of members in the target outreach list was 2,172. The combined outreach rate at the end of cycle 1 was 53.22% (1,156/2,172).

Barriers

Two of the five initial provider offices were unable to complete the member outreach. Provider Office 1 had a reorganization to their outreach department that led them to be short staffed and unable to reach their goal. Provider Office 3 had limited staff resources and were unavailable to perform outreach functions. Provider Office 1 and 2 have a team who perform outreach as part of their role. Provider Office 3 has only one staff member available to conduct member outreach.

Opportunities for Improvement

- CalOptima health will attempt different engagement strategies. For members who are hard-to-reach via phone, a member mailing will be sent out after telephone outreach to increase awareness about cervical cancer screenings.
- Obtaining Provider Office staff feedback is crucial to intervention implementation success. HN staff reported more frequently when they were notified that the member outreach was delayed due to staff availability.
- More time is needed to determine if the member reminder notice was successful (voice mail messages, mailing) and if members are willing to schedule cervical cancer screening. For cycle 2, provider offices will continue to outreach members on the target list and monitor if they were able to schedule or completed cervical cancer screening.
- Receiving tracking logs quarterly, allowed the HN staff to address issues and provide feedback to CalOptima Health that may not be identified until the end of the year. We were able to identify members (13 members) who had received cervical cancer screenings elsewhere.
- The intervention completed in this cycle focused on provider office staff reaching out to members to schedule cervical cancer screenings. For cycle 2, provider office staff will continue to focus on

contacting members to schedule cervical cancer screening. CalOptima Health plans to add a provider office staff incentive that focuses on the number of completed cervical cancer screenings.

Pediatric Strategy 3- Increase Childhood Immunization Status (CIS-Combo 10) Rate for CalOptima Medi-Cal Members with Provider Office A (October 1, 2021–September 30, 2022)

CalOptima Health identified provider offices that had a high volume of CalOptima Health Medi-Cal members due for childhood vaccinations and low performing for the Childhood Immunization Status (CIS-Combo 10) HEDIS measure. Vaccinations included: DTAP, IPV, MMR, HiB, Hep B, VZV, Pneumococcal conjugate, Hep A, RV, Influenza. [3]

a. **Goal:** COVID 19 QIP Strategy 3 aimed to increase immunization rates of Medi-Cal members turning 2 years of age who were due for vaccinations.

b. **Target Audience:** Provider Office A had 663 Medi-Cal members who fell in the CIS-Combo 10 denominator for MY 2021. The target outreach population was 611 child members

c. **Intervention:** The Provider Office had a CIS-Combo 10 rate of 7.84% based on claims and encounters processed through August 2021. The NCQA 50th Percentile Benchmark for CIS-10 is 38.20%. The intervention included a single provider office contacting the parent, or guardian, via telephone whose child was due for an immunization(s). The purpose of the intervention was to increase immunization rates. CalOptima Health provided a target list of

[3] DTAP – diphtheria, tetanus toxoid, acellular pertussis; IPV – inactivated poliovirus; MMR – measles, mumps, rubella; HiB – haemophilus influenzae type b; Hep B – hepatitis B; VZV – varicella zoster virus; Hep A – hepatitis A; RV - rotovirus

members due for an immunization to the provider office which contacted the parent, or guardian, to educate them on the importance of vaccinations, schedule appointment(s) and complete visits/vaccinations. These efforts were measured and equated to the provider office staff incentive (POSI). The provider office staff incentive tier payment system was be based on metrics as established by CalOptima Health.

Findings

a. Cycle 1: October 2021–December 2021

   i. Metric 1: POSI was based on the percentage of members contacted with outcomes tracked on the member target list by 12/31/21. The provider office contacted all of their target list. Out of 611 members who were due for vaccinations, 557 were successfully contacted on the first call attempt. Furthermore, 26 additional members were successfully reached on second call attempt. Of the 28 members unable to be reached by telephone, 18 received a letter by mail. For 10 members, no additional outreach was performed since the member had not established care with the provider.
   ii. Metric 2: POSI was based on the percentile Provider Office's MY 2021 CIS-Combo 10 rate meets by 12/31/21. This will be based on administrative data only.

      1. Based on December 2021 Prospective Rate Report, Provider Office CIS-Combo 10 rate, the Provider Office rate was 44.34%, which is the 66th percentile based on NCQA Quality Compass Benchmarks as of September 24, 2021.

b. Cycle 2: January 2022–March 2022

   i. Due to HEDIS data limitations, no target list was provided to the Provider Office during this measurement period. CalOptima Health continued to provide guidance and acted as a liaison for inquiries for the Provider Office staff. Cycle 2 allowed for data collection through claims and encounters to establish baseline for calendar year 2022. Based on February 2022 Prospective Rates, Provider Office CIS-Combo 1, the office rate was 31.91% (216/677).

c. Cycle 3: April 2022–June 2022

   i. Metric 1: POSI was based on the percentage of member records reconciled and an outreach was attempted. Call outcomes were tracked on the member target list by 06/30/2022.

      1. Provider Office reconciled and provided documentation demonstrating that they made an outreach attempt to 100% of their target list.

   ii. Metric 2: POSI was based on the number of members who completed their scheduled appointments. The Provider Office documented scheduled appointments on the member target list and indicated if the visit was completed. Visits were validated through claims and encounters data. The time period was 04/18/2022–06/30/2022.

1. The Provider Office was able to meet a 72% scheduling rate. There are 339 members who have not aged out of the measure and were due for vaccinations. CalOptima Health was able to confirm through data reconciliation that 100 members were compliant; 10 members were removed from the denominator due to being ineligible or other factors. Furthermore, 78 members had a successful appointment from 04/01/2022, 7 members completed their visit after 6/30/2022 and, 48 members were in on-hold while waiting for the influenza vaccine to become available.

d. Cycle 4: July 2022–September 2022

    1. Intervention cycle was completed. The validation findings are still pending.

Analysis

a. The Provider Office was able to successfully reconcile 100% of the target list with internal medical records and provided feedback.

b. The Provider Office was able to contact the parent or guardian of the members who were due for vaccinations and schedule their appointments.

c. The Provider Office was also able to document the reasons why members were unable to complete all of their vaccinations, e.g., refused the influenza vaccination.

Barriers

a. Members refused the influenza vaccination.

b. Members missing rotavirus vaccination and completing the dosage off-schedule.

c. Influenza vaccine availability may impact the member's compliance.

d. The vaccination schedule begins at birth. If a member is off-schedule and is trying to catch-up, it makes it difficult to complete all 10 vaccinations by 2 years of age.

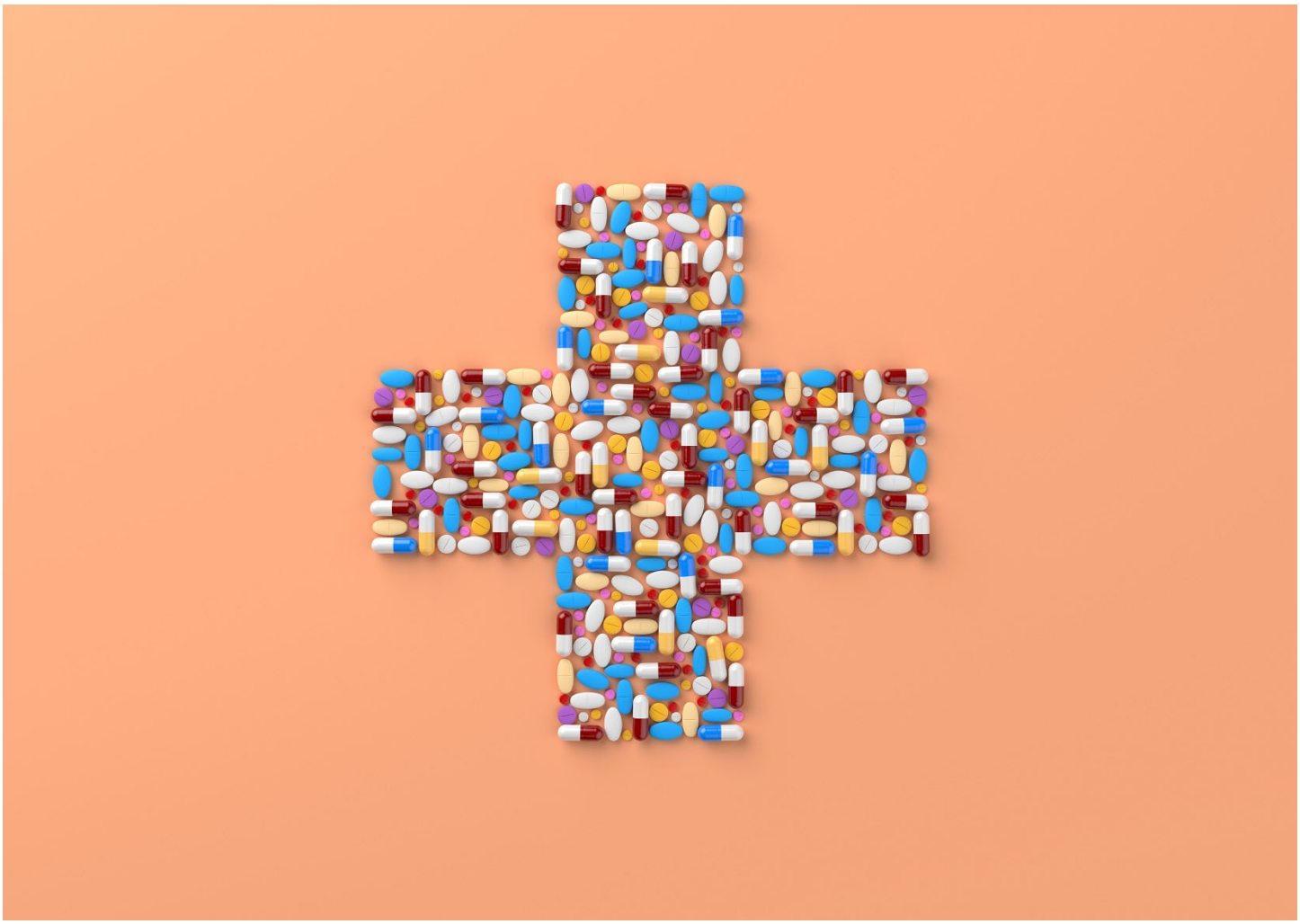
Opportunities for Improvement

a. CalOptima Health will begin contacting members who are due for vaccinations early-on instead of waiting until the measurement year when member turns 2 years old.

b. CalOptima Health will develop member health education tools regarding vaccinations to aid the conversation between providers and members, and to reduce the rate of vaccination refusal.

Patient Safety QIP– OneCare Connect Population and Medi-Cal

To improve statin adherence for patients with diabetes intervention, a mailing was sent that targets all three lines of business: Medi-Cal (MC), OneCare (OC) and OneCare Connect (OCC). The Medi-Cal results are reported to NQQA to satisfy the Patient Safety standard. The OneCare Connect results are reported to CMS as part of a QIP.



Improving Statins Use for Patients with Diabetes (SPD) 2019–21

a. Per the MY 2021 HEDIS Technical Specifications, the description of the SPD measures is the percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who meet the following criteria. Two rates are reported:

b. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.

c. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

d. The improving statin adherence for patients with diabetes intervention is a mailing that targets all three lines of business: Medi-Cal (MC), OneCare (OC) and OneCare Connect (OCC).

    i. **Goal:** By the end of the year, the goal was to reduce the rate of members who have yet to receive therapy/maintain adherence by five percentage points.

ii. **Target Population:** All CalOptima Health members who are diagnosed with diabetes.

iii. **Interventions:** A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima Health members diagnosed with diabetes. A 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 provider about whether a statin is best for them.

iv. **Activities:** Quarterly mailings were initiated to encourage members to consider the benefits of preventing cardiovascular complications. This mailer was sent to an average of 4,476 members in 2021. Data collection was performed by LOB to track and monitor throughout 2021.

Findings

a. For 2021, the baseline was modified and updated because members who have yet to receive therapy/maintain adherence in the SPD adherence and therapy sub measures in Q1 2021 were included. This updated baseline was set at 29.96%. This represents the rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measure. For each quarter, members who have yet to receive therapy/maintain adherence were sent the statin mailer. The overall goal of this intervention in 2021was to reach the target goal of ≤ 24.96% (a lower percentage is an improvement) a 5-percentage point decrease. Toward the end of 2021, the numerator and denominator decreased. However, the rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measures was 32.58% and did not meet the target goal of 24.96%. There was a 7.89 percentage point increase of members who have yet to receive therapy/maintain adherence.

Table 1: SPD Adherence Sub-measure

	Description	*Baseline 2020*	*2020 Results*
	Total Number of Population	1,242	1,562
B1a	**Number of Enrollees who have yet to maintain adherence (adherence measure):**	260	291
B1b	**Number of Enrollees who were in adherence measure:**	1,242	1,562
B1	**Results and/or Percentage:**	20.93%	18.63%

SPD Adherence 2020 Prospective Rate Data and 2021 SPD Mailer Data

Table 2: SPD Therapy and Adherence Sub-measure

	Description	*Baseline 2021*	*2021 Results*
	Total Number of Population	2,193	2,004
B1	**Number of Enrollees who have yet to receive therapy/maintain adherence (therapy & adherence measures):**	657	653
B1b	**Number of Enrollees who were in therapy & adherence measures:**	2,193	2,004
B1	**Results and/or Percentage:**	29.96%	32.58%

SPD Therapy Adherence 2021 Prospective Rate Data 2021 SPD Mailer Data

a. We unable to compare the 2021 result to 2020 result since it is not a direct correlation to trend year over year due to the change in measurement methodology. Towards the end of 2020, the rate was 18.63% but this is only for the SPD non-adherent (members who have yet to maintain adherence) members only. The SPD adherence sub-measure was the focus of the intervention in 2020, but in 2021 the SPD Therapy sub-measure was included. A better comparison of the 2021 rate will be available in the next evaluation, since the 2022 methodology includes both members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measures.

b. Table 5 and Table 6 depict the ethnic breakdown of the SPD sub-measures. The Vietnamese, Filipino and Asian or Pacific Islander ethnic groups met the key performance indicator (KPI) for these two sub-measures. The Hispanic, White and Black did not meet the KPI and will be the focus of priority in 2023. The categories of No response and Other do not contain enough information to make any determination.

Table 5: SPD Statin Adherence

All LOBs	**Race/Ethnicity**									
HEDIS MY 2021	*Hispanic*	*Vietnamese*	*White*	*No response*	*Other*	*Filipino*	*Asian or Pacific Islander*	*Korean*	*Black*	*Asian Indian*
Numerator	4,678	2,939	1,716	1,676	452	450	385	62	167	190
Denominator	7,045	3,529	2,409	2,245	613	529	488	344	259	259
Rate	66.40%	83.28%	71.23%	74.65%	73.74%	85.07%	78.89%	81.98%	64.48%	73.36%
KPI (QC 50th %)	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%
Met/Not Met	Not Met	**Met**	Not Met	Not Met	Not Met	**Met**	**Met**	**Met**	Not Met	Not Met

HEDIS MY 2021 SPD Statin Adherence sub measure results. Based on the top 10 highest race/ethnicity denominators. Four out of the 10 Race/Ethnicity met the 50th percentile for Hemoglobin A1c Testing.

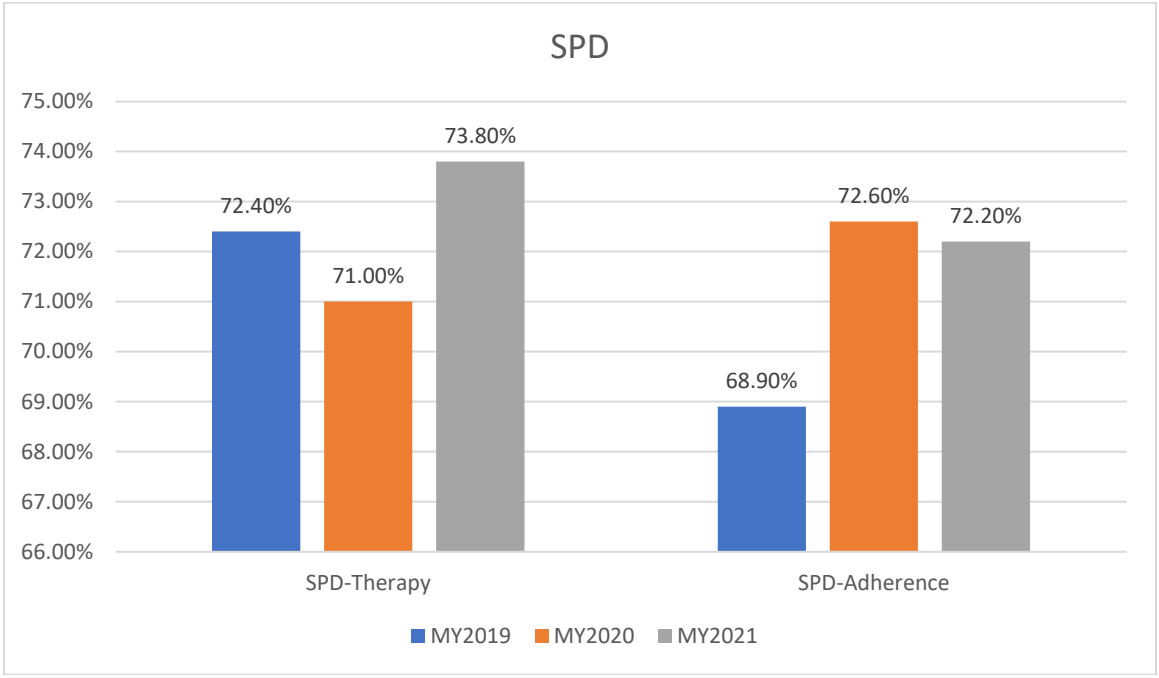
Table 6: SPD Received Statin Therapy

All LOBs	Race/Ethnicity									
HEDIS MY 2021	*Hispanic*	*Vietnamese*	*White*	*No Response*	*Other*	*Filipino*	*Asian/Pacific Islander*	*Korean*	*Black*	*Asian Indian*
Numerator	7,045	3,529	2,409	2,245	613	529	488	344	259	259
Denominator	9,849	4,148	3,515	3,042	806	629	621	427	411	334
Rate	71.53%	85.08%	68.53%	73.80%	76.05%	84.10%	78.58%	80.56%	63.02%	77.54%
KPI (QC 50th %)	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%
Met/Not Met	Not Met	**Met**	Not Met	Not Met	**Met**	**Met**	**Met**	**Met**	Not Met	**Met**

HEDIS MY2021 SPD Received Statin Therapy sub-measure results. Based on the top 10 highest race/ethnicity denominators. Six out of the 10 Race/Ethnicity met the 50th percentile for Hemoglobin A1c Testing.

a. Figure 1 shows the Medi-Cal HEDIS MY 2019, MY 2020, MY 2021 results for SPD Therapy and SPD Adherence. When comparing MY 2020 to MY 2021 SPD Therapy rates, the rate increased by 2.80 percentage points. When comparing MY 2020 to MY 2021 SPD Adherence rates, the rate decreased by 0.40 percentage points.

Figure 1: SPD HEDIS MY 2021 Results: Medi-Cal



SPD Therapy and Adherence rates by measurement year (MY)

a. Table 7 identifies the reporting requirements and goals for SPD and its sub-measures. This is used to track progress and ensure compliance as a health plan.

Table 7: SPD HEDIS MY 2021 Goals, Medi-Cal

HEDIS Measure	Percentile, Goal, Reporting Requirements					
HEDIS MY 2021 Medi-Cal	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*		*Goal*	*Reporting Requirements***
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.47%	68.57%	72.23%	**72.23%**	HPR	
Met/Not Met			Met MY 2021 Goal, met 90th percentile			
Statin Therapy for Patients with Diabetes (SPD) - adherence	64.95%	71.95%	80.00%		**73.43%**	HPR
Met/Not Met		Did not met MY 2021 Goal, met 66th percentile				

*SPD Therapy and Adherence results MY 2021 Medi-Cal. ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value*

a. Figure 2 shows the OneCare Connect HEDIS MY 2019, MY 2020, MY 2021 results for SPD Therapy and SPD Adherence. When comparing MY 2020 to MY 2021 SPD Therapy rates, the rate increased by 1.60 percentage points. When comparing MY 2020 to MY 2021 SPD Adherence rates, the rate increased by 6.10 percentage points.

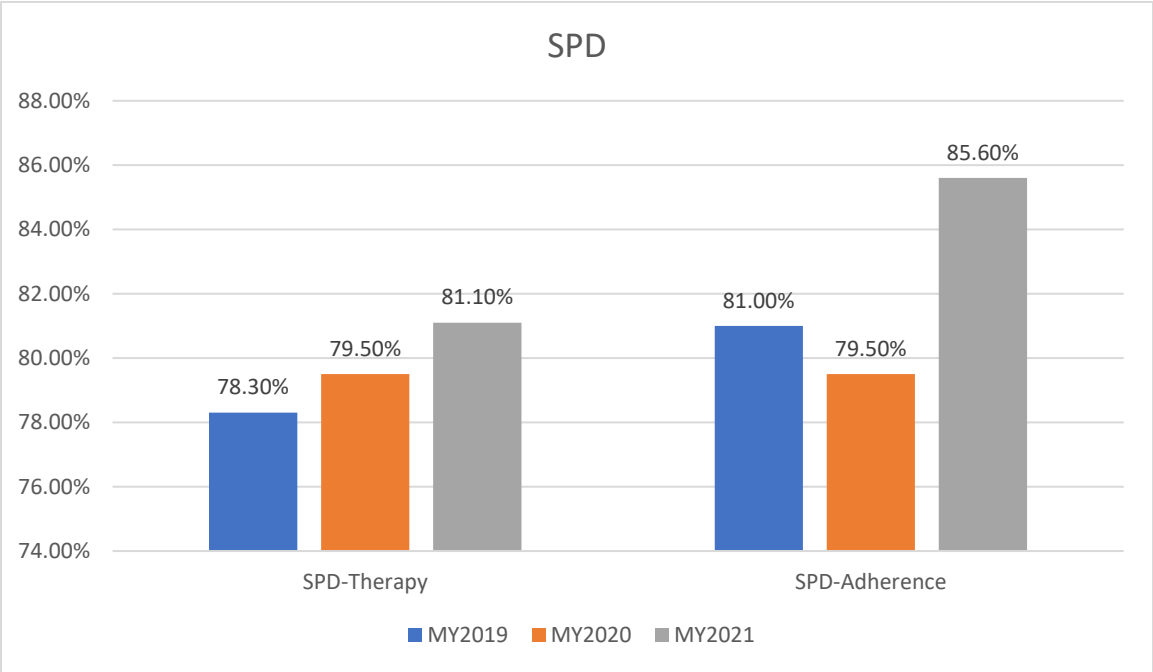
b. Table 8 shows the 2021 and 2022 SPD Therapy and Adherence measure Prospective Rate Data for Medi-Cal. When comparing the rates from September 2022 and September 2021, both SPD measures show a 4.5 percentage point increase for Statin Adherence and a 0.55 percentage point increase for Statin Therapy. This reflects the positive impact of the SPD intervention.

Table 8: September Prospective Rates for SPD – Medi-Cal

September Prospective Rates	SPD Statin Adherence		SPD Statin Therapy	
Medi-Cal	*September 2021*	*September 2022*	*September 2021*	*September 2022*
Numerator	7,665	8,589	15,308	17,871
Denominator	15,308	17,871	21,831	25,503
Rate	50.07%	48.06%	70.12%	70.07%
KPI (QC 50th %)	64.25%	68.75%	65.92%	66.47%
Met/Not Met	Not Met	Not Met	**Met**	**Met**

SPD Therapy and Adherence 2021 Prospective Rate Data 2021

Figure 2: SPD HEDIS MY 2021 Results – OneCare Connect



SPD Therapy and Adherence rates by measurement year (MY)

a. Table 9 identifies the reporting requirements and goals for SPD and its sub-measures. This is used to track progress and ensure compliance as a health plan.

Table 9: Goals, OneCare Connect

HEDIS Measure	**Percentile, Goal, Reporting Requirements**				
HEDIS MY 2021 OneCare Connect	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*	*Goal*	*Reporting Requirements***
Statin Therapy for Patients with Diabetes (SPD) - therapy	81.00%	84%	89%	**81.00%**	Star
Met/Not Met	Met MY 2021 goal, met 33rd Percentile				
Statin Therapy for Patients with Diabetes (SPD) - adherence	83.23%	87.35%	90.94%	**82.27%**	CMS
Met/Not Met	Met MY 2021 goal, met 33rd Percentile				

*SPD Therapy and Adherence results MY 2021 OneCare Connect. *Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference*

a. Table 10 shows the 2021 and 2022 SPD Therapy and Adherence measure Prospective Rate Data for OneCare. When comparing the rates from September 2022 and from September 2021, both SPD measures show a 4.5 percentage point increase for Statin Adherence and a 0.55 percentage point increase for Statin Therapy. This reflects the positive impact of the SPD intervention.

Table 10: September Prospective Rates for SPD – OneCare

September Prospective Rates	**SPD Statin Adherence**		**SPD Statin Therapy**	
OneCare Connect	*September 2021*	*September 2022*	*September 2021*	*September 2022*
Numerator	946	931	1,585	1,694
Denominator	1,585	1,694	2,007	2,105
Rate	59.68%	54.96%	78.97%	80.48%
KPI (QC 50th %)	78.03%	83.76%	74.13%	77.77%
Met/Not Met	Not Met	Not Met	**Met**	**Met**

SPD Therapy and Adherence 2021 Prospective Rate Data 2021

Analysis

a. CalOptima Health's desired outcome was to help reduce the number of non-adherent members by targeting outreach efforts. To meet this objective, the pharmacy department provided a list of members for outreach to provider offices every quarter in 2021. The Pharmacy department met their objectives for 2021 by strategizing their outreach methodology.

b. CalOptima Health's Population Health Management department similarly utilized the Pharmacy department's member list for a statin information and education mailer. The statin member mailer included a cover letter to encourage members to talk to their doctor about statins as well as the "What is a Statin?" fact sheet document and provided contact information for members with questions. The objectives of this initiative were met since the mailer was sent to 100% of the members on the priority list.

c. When analyzing the 2021 results in the table above, the results show that there was an increase in the SPD Therapy and Adherence sub-measure rate. By having multiple methods to target providers and members, the rate for 2021 improved.

Barriers

a. Claims lag created a challenge for this intervention. Since a direct correlation could not be established, data needed to be compared at the end of the year. Data was checked to see if the members had filled a statin medication and if the member remained on a statin medication of any intensity for at least 80% of the treatment period.

b. Changing the members' behavior toward medication adherence is another barrier. It may take time and multiple attempts for these interventions to take effect since medication adherence is behavior dependent.

c. Members may be reluctant going to the pharmacy to get their medications due to the impact of the COVID-19 pandemic.

d. Obtaining the medication may also be a factor. Providers reported that socioeconomic status may affect the members' ability access to medication. Lack of transportation plays a factor in the access to medication as well as members may be unable to get to the pharmacy. It was also reported that members were concerned regarding the potential interactions of statins with other medications or alcohol, causing some members to wait for their body to process the alcohol or other medications first and before taking the medication.

e. In Q3 2021, the mailing distribution was delayed due to an urgent COVID-19 ad-hoc mailer that required distribution during the same timeframe.

f. In Q4 2021, the mailing distribution was delayed due to a DHCS audit that occurred during the same timeframe.

Opportunities for Improvement

a. If the drug medication formulary changes for statins changes, the "What is a Statin?" document may need to be updated. Providing the member with a medication list that is consistent with the formulary will help ensure the medication is covered. Completing the fulfillment of statin mailers as early as possible will ensure timely dissemination.

b. Working with CalOptima Health's Pharmacy department is considered a best practice for this intervention. This multipronged approach not only provided a medium for providers to outreach to those non-adherent members, but it also allowed Population Health Management to target specific members and reduce the number of non-adherent members. Also, utilizing the Pharmacy department's "What is a Statin?" fact sheet document for our member mailers ensures consistent messaging and statin information. In addition, the "What is a Statin?" fact sheet document also encouraged members to speak with their doctor about statin medication, which is aligned with improving statin use and adherence among these members.

c. For future member targeted efforts beyond 2022, Population Health Management will consider pulling its own member list eliminating the dependency on the Pharmacy department and improving the time needed for printing, fulfillment and distribution of the mailing.

Chronic Care Improvement Programs (CCIPs) (All Lines of Business)

On December 9, 2019, CMS informed Medicare Advantage Organizations and Medicare-Medicaid Plans that they are required to attest that they have, or will have, an ongoing Chronic Care Improvement Program (CCIP) with a focus on promoting effective management of chronic disease. CalOptima Health chose to focus on diabetes, particularly members who fall in the category of "emerging risk," defined as a new lab hemoglobin A1c (HbA1c) levels 8.0–9.0 when previously under 8%, as the target condition for this CCIP. These members are at higher risk of having uncontrolled diabetic management. The rationale for targeting this population is to assist members with newly emerging risk before they reach the point of poor HbA1c control, defined as a HbA1c levels 9.1 or above, and assist with their management to return below an HbA1c of 8%.

Emerging Risk Health Coaching Telephonic Outreach CCIP

a. In an effort to address emerging risks 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 as Emerging Risk members. Telephonic outreach was conducted by a health coach to identify solutions for Emerging Risk members to manage their HbA1c levels below 8.0%.

Findings

a. Medi-Cal: When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, there was trend of increased successful outreach for each quarter.

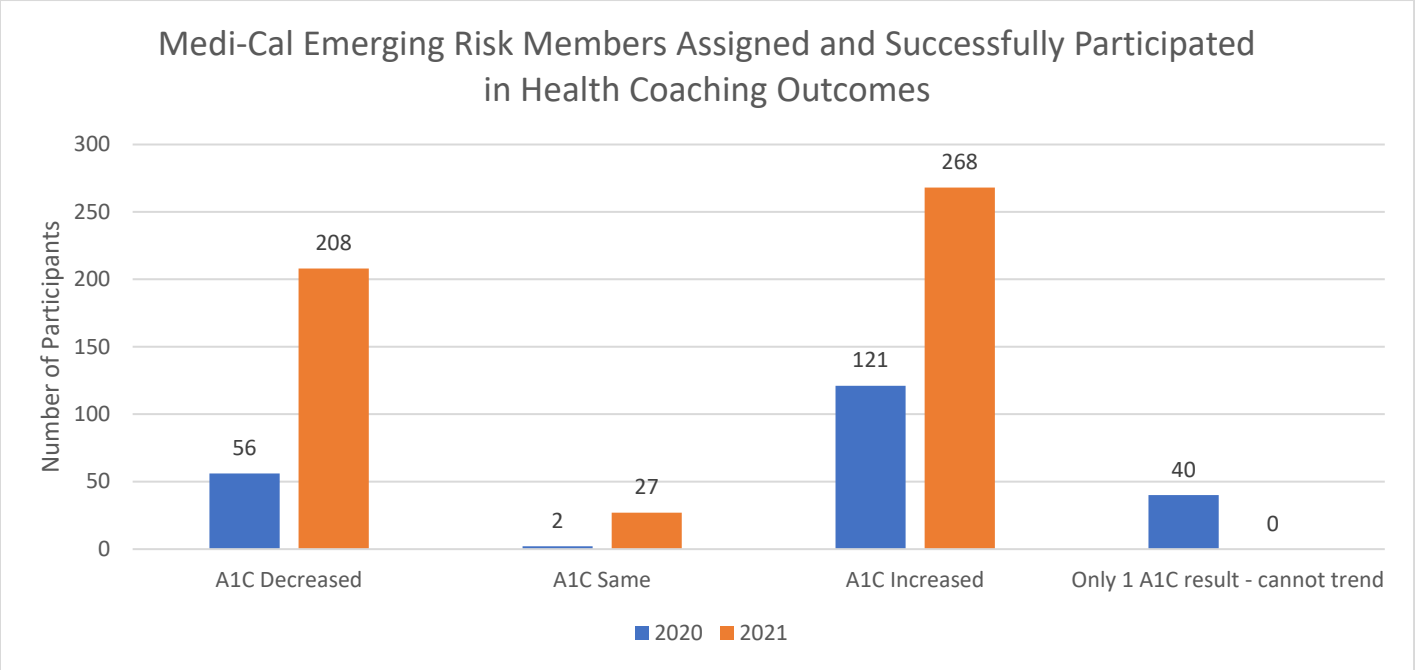
b. On a quarterly basis when the outreach outcomes were compared from 2020 and 2021, there is an upward trend. Figure 1 depicts the improvement of successful outreach attempts to members in 2021 when compared with the same quarter the previous year in 2020.

Figure 1: Medi-Cal Emerging Risk Member Health Coach Telephonic Outreach

a. In 2022, the Health Coach telephonic outreach to Emerging Risk Medi-Cal members was 57.74% to 67.11.% each quarter, and it was higher every quarter than in outreach attempts in 2021.

b. Emerging Risk is defined as a HbA1c between 8.0 to 9.0. During the intervention, members were tracked to identify how many Emerging Risk members improved their HbA1c, stayed the same or worsened. When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a reduced HbA1c result in 2021. Figure 2 illustrates in 2021 208 participants had HbA1c outcomes reduced while 268 participants had HbA1c outcomes increased.

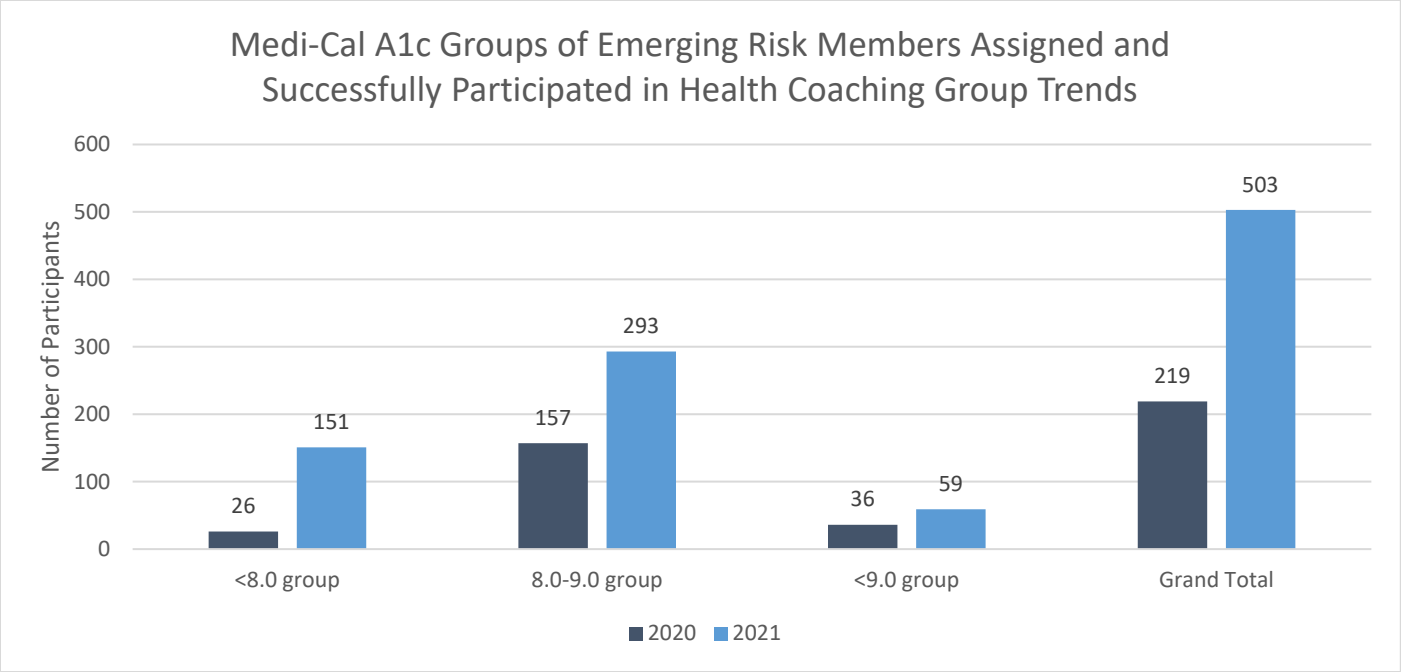
Figure 2: 2020 and 2021 Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' HbA1c Trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

a. When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "A1c <8.0 group" (26/219 = 11.87%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (151/503 = 30.02%), the rate improved by 18.15%. Members who participated in telephonic outreach experienced a reduction in their HbA1c. Yet, in 2021, there were 293 members who fell into the Emerging Risk category who had an increase when compared with 2020.

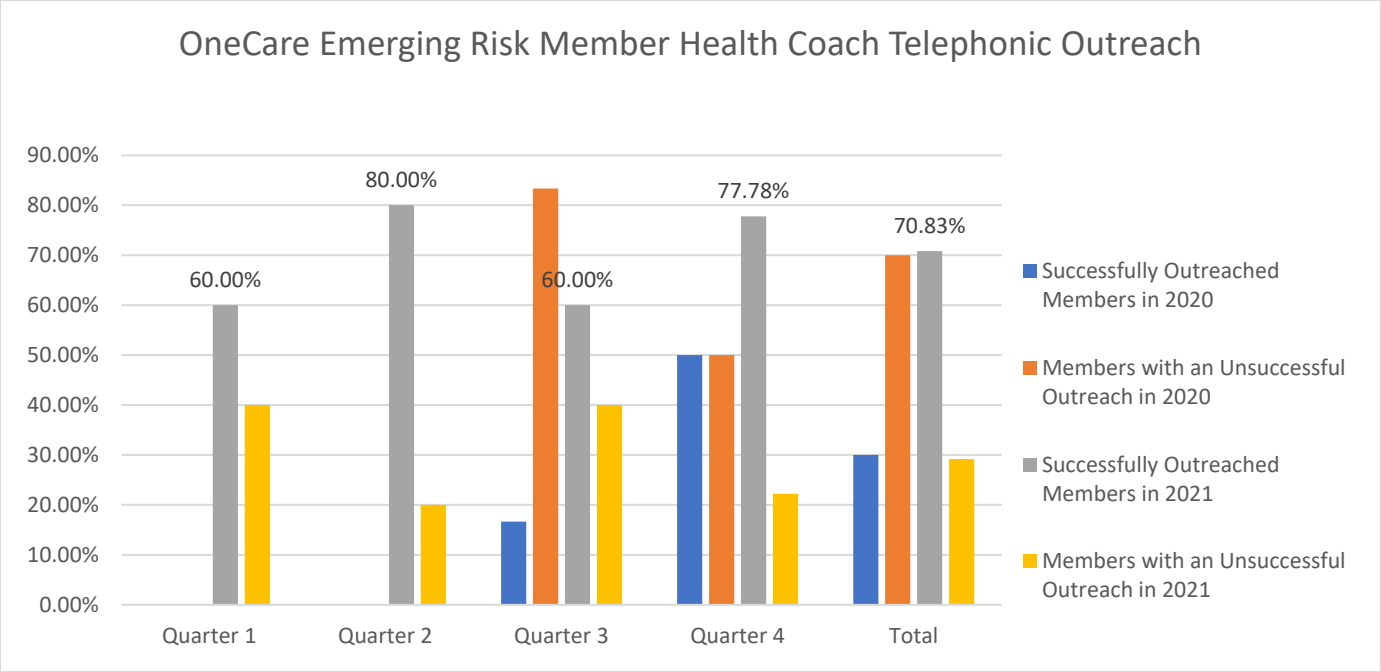
Figure 3: 2020 Medi-Cal HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

a. OneCare: When comparing the rates of Emerging Risk members with a successful contact by a Health Coach for each quarter in 2020 to the respective quarter in 2021, there was trend of increased successful outreach for each quarter. Figure 4 showcased the rate of outreach per assigned member in 2020 and 2021. There was a significant improvement in the rate of successful outreach attempts to members in 2021.

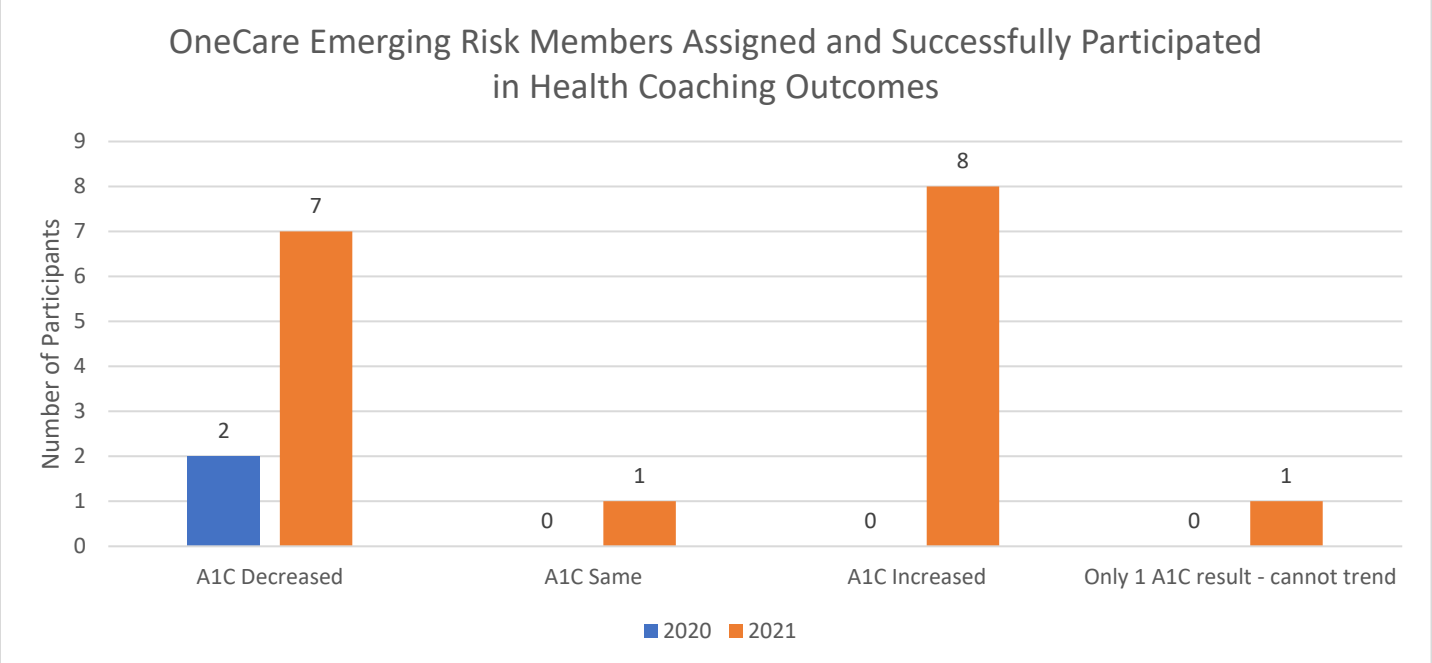
Figure 4: OneCare Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (2nd column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (3rd column) and rate of assigned Emerging Risk members with an unsuccessful outreach (4th column).

a. When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Yet, there was a significant number of members whose HbA1c increased after participating in the program, as depicted in Figure 5.

Figure 5: OneCare Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



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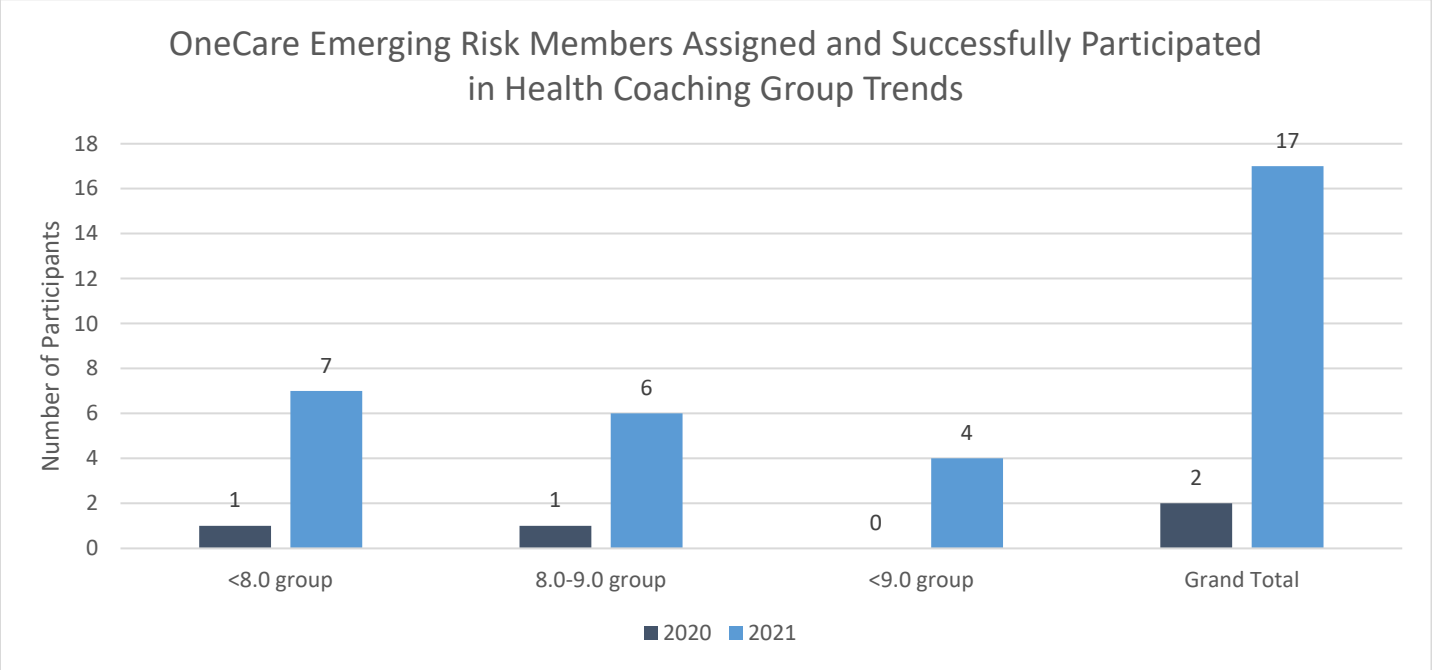
The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' HbA1c Trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

a. When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" (1/2 = 50.00%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (7/17 = 41.18%), the rate improved by 8.82% but there were more members who were assigned and fell into the HbA1c <8.0 group in 2021. Further details are depicted in Figure 6.

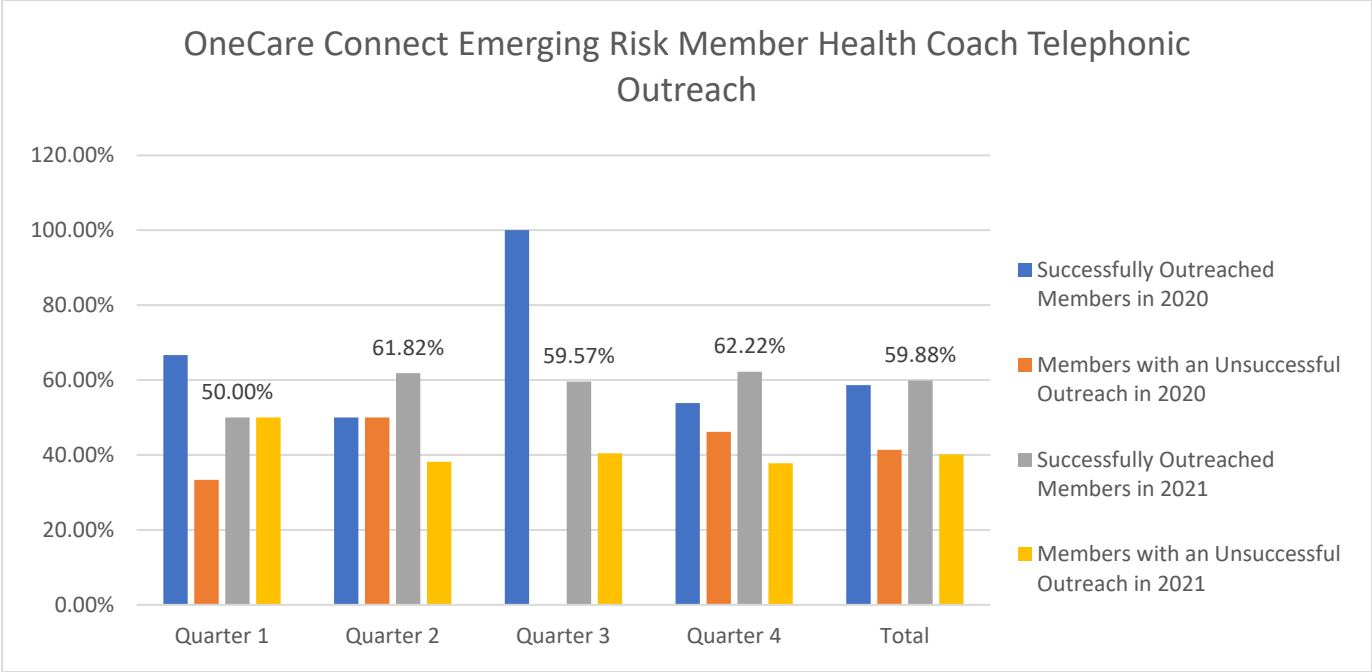
Figure 6: OneCare HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c groups they fell into at the end of 2020 and 2021.

b. OneCare Connect (OCC): When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, the trend varied for each quarter but overall, there was an improvement in 2021 by 1.26%.

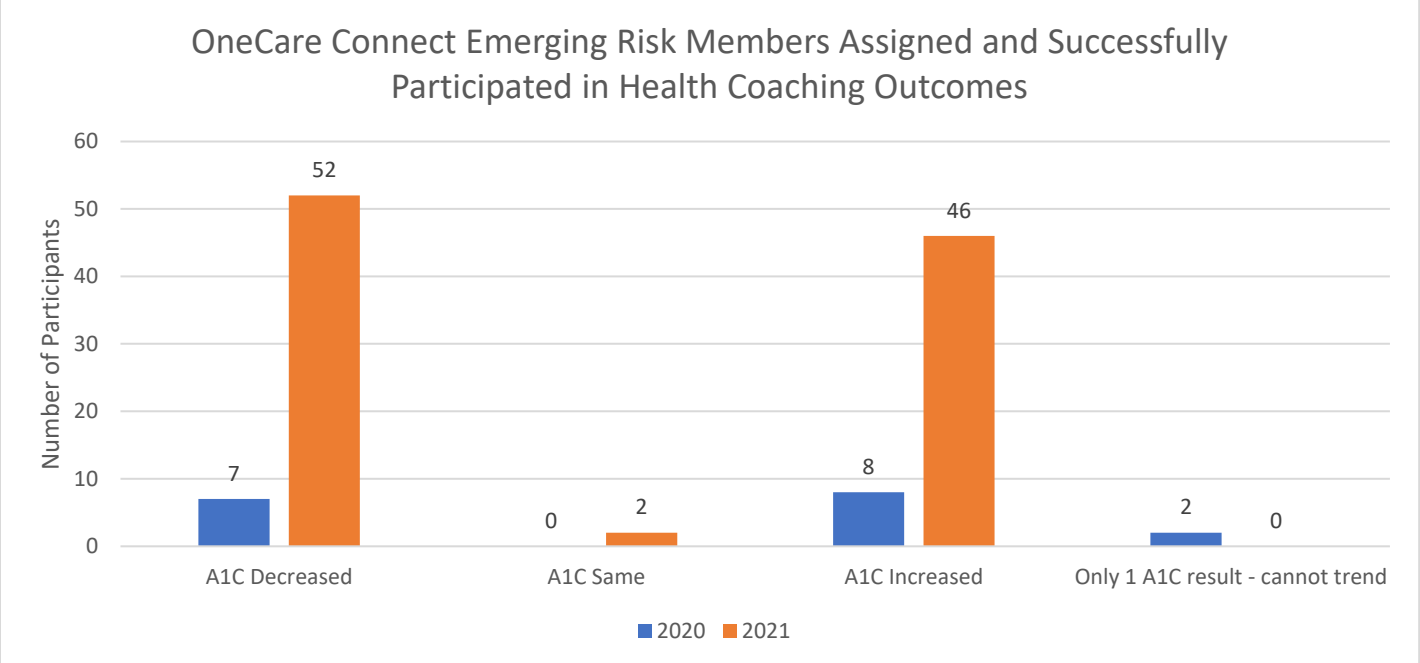
Figure 7: OneCare Connect Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (2nd column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (3rd column) and rate of assigned Emerging Risk members with an unsuccessful outreach (4th column).

a. When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Figure 8 demonstrates that for the OneCare Connect population in 2021 this program helped reduce the HbA1c for most participants.

Figure 8: OneCare Connect Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



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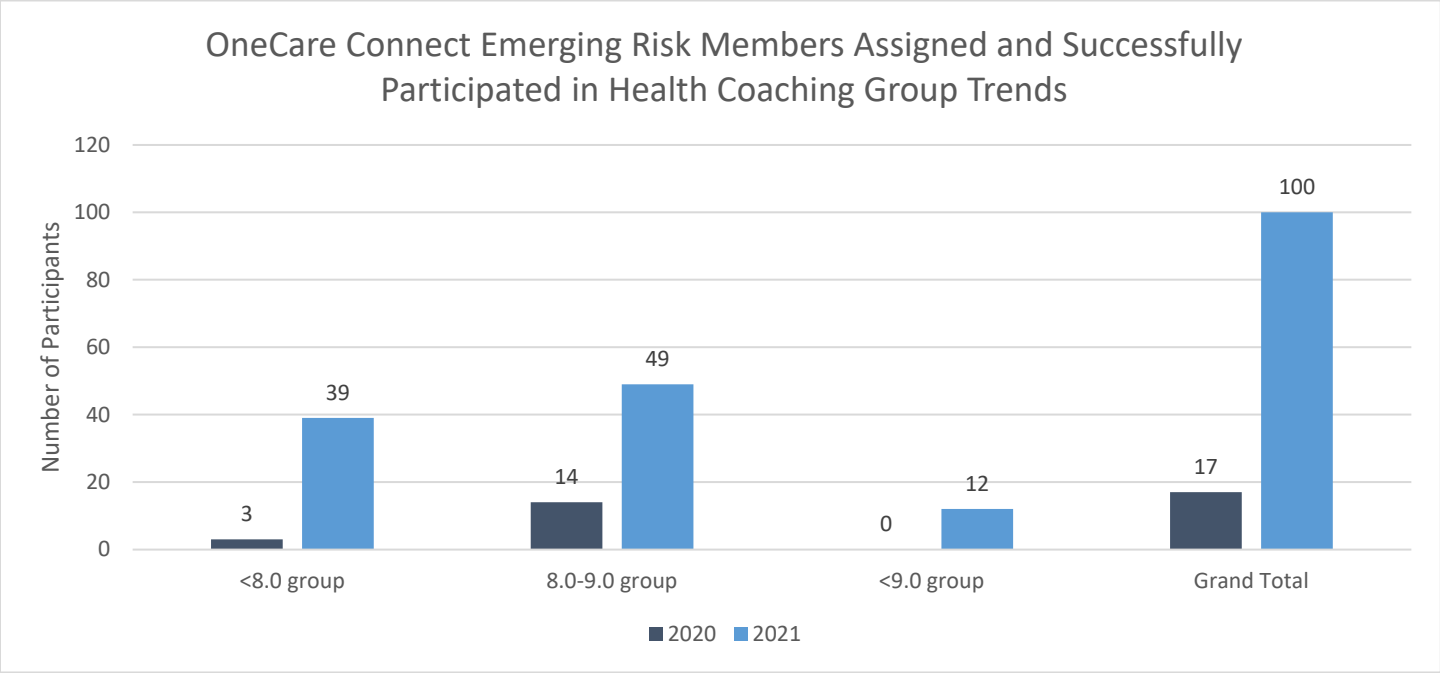
The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' HbA1c trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

a. When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" (3/17 = 17.65%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (39/100 = 39.00%), rate improved by 21.35%.

Figure 9: OneCare Connect HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

a. Table 1 illustrates the HEDIS rate based on race and ethnic breakdown.

Table 1: All LOBs HEDIS MY 2021 Rates by Race/Ethnicity CDC HbA1c Testing

Table S	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Filipino	Asian/Pacific Islander	Black	Korean	Asian Indian
Numerator	14,589	4,993	5,190	4,427	1,157	913	758	598	571	480
Denominator	17,274	6,182	5,719	5,223	1,372	1,022	865	753	667	548
Rate	84.46%	80.77%	90.75%	84.76%	84.33 %	89.33%	87.63%	79.42%	85.61%	87.59%
KPI (QC 50th %)	89.30%	89.30%	89.30%	89.30%	89.30 %	89.30%	89.30%	89.30%	88.66%	89.30%
Met/Not Met	Not Met	Not Met	**Met**	Not Met	Not Met	**Met**	Not Met	Not Met	Not Met	Not Met

HEDIS MY 2021 CDC HbA1c Testing sub-measure results. Based on the top 10 highest race/ethnicity denominators. Two out of the 10 Race/Ethnicity met the 50th percentile for HbA1c Testing.

Analysis

a. Medi-Cal

i. Goal: By 12/31/2021, the target goal of this intervention would be to reduce the number of Medi-Cal emerging risk members by 5% for those who participated in the telephonic health coaching intervention.

ii. As shown in the findings section, out of the 503 members who successfully participated in Health Coaching, 151 members fell into the <8.0 group, which gives a rate of 30.02%. There were 293 members that remained in the 8.0–9.0 group (Emerging Risk) from the 503 members that successfully participated in Health Coaching, which gives a rate of 58.25%. The target goal for this intervention was to reduce the number of Medi-Cal Emerging Risk members by 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 503. To achieve a 5% reduction of that figure, we needed at least 26 Emerging Risk members to be placed in the <8.0 group by the end of the year. The 2021 outcomes show that there were 151 Emerging Risk members who participated in the telephonic health coaching outreach placed in the <8.0 Group (good control). This indicates that we met the goal of reducing the emerging risk members by 5%.

b. OneCare

i. Goal: By 12/31/2021, the target goal of this intervention would be to reduce the number of OneCare Emerging Risk members by 50% for those who participated in the telephonic health coaching intervention.

ii. As shown in the findings section out of the 17 members that successfully participated in Health Coaching, 7 members fell into the <8.0 group, which gives a rate of 41.18%. There were 6 members who remained in the 8.0–9.0 group (Emerging Risk) from the 17 members who successfully participated in Health Coaching, which gives a rate of 35.29%. The target goal for this intervention was to reduce the number of OneCare Emerging Risk members by 50% (from baseline of 5) by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 17. To achieve a 50% reduction of that figure we needed at least 9 Emerging Risk members to be placed in the <8.0 group by the end of the year. The 2021 outcomes show that there were 7 Emerging Risk members who participated in the telephonic health coaching outreach placed in the <8.0 Group (good control). This indicates that we did not meet the goal of reducing the Emerging Risk members by 50%.

c. OneCare Connect

i. Goal: By 12/31/2021, the target goal of this intervention would be to reduce the number of OneCare Connect Emerging Risk members by 5% for those who participated in the telephonic health coaching intervention.

ii. As shown in the findings section, out of the 100 members who successfully participated in Health Coaching, 39 members fell into the <8.0 group, which gives a rate of 39%. There were 49 members that remained in the 8.0–9.0 group (Emerging Risk) from the 100 members who successfully participated in Health Coaching, which gives a rate of 49%. The target goal for this intervention was to reduce the number of OneCare Connect Emerging Risk members by 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members that received the telephonic health coaching intervention was 100. To achieve a 5% reduction of that figure we needed at least 5 Emerging Risk members to be placed in the <8.0 group by the end of the year. The 2021 outcomes show that there were 39 Emerging Risk members who participated in the telephonic health coaching outreach placed in the <8.0 Group (good control). This indicates that we met the goal of reducing the Emerging Risk members by 5%.

Barriers

Barriers encountered during the Health Coach telephonic outreach include:

a. Limited capacity for the health educators to conduct outbound calls due to their competing volume of daily tasks.

b. Difficulty with scheduling appointments. Appointments are very far away, especially with endocrinologist due to limited office hours.

c. With the COVID-19 pandemic, telehealth appointments were difficult for some members due to the lack of access to a smartphone or not understanding the instructions on how to connect to video calls.

d. Members relying on natural remedies to reduce their blood sugar.

e. Members face challenges with access to broadband internet based on their economic status or place of residence.

f. Members may require transportation to attend appointments and may be unaware of their transportation benefits.

Opportunities for Improvement

a. Instruct Health Coaches to assist members with scheduling appointments whenever possible. Teach members how to navigate the health system and telehealth appointments. Encourage members to communicate needs and challenges timely to their provider.

b. During outbound calls conduct a short questionnaire screening for social determinants of health and connect members with other resources to assist specific needs.

c. Update telephonic scripting to offer resources for members with diabetes and provide information regarding telehealth services.

d. Seek ways to improve data needs and streamline how members are assigned to the Health Coaches, moving from manual to an automated method.

e. Conduct a multi-layered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine if social determinants of health are creating barriers for CalOptima Health members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.

Model of Care: Plan Performance Monitoring and Evaluation and Quality Improvement Program Effectiveness – Health Risk Assessments

Monitoring of dashboard performance and effectiveness by Case Management for OneCare and OneCare Connect in 2022 continued with the same metrics as performed in 2021. Two additional metrics were added related to Health Risk Assessment (HRA)s, in the Long-Term Care (LTC) population; and a goal-target for California Medicare-Medicaid plans (CA) 1.5 was defined.

OneCare and OneCare Connect

Interventions

Case Management's interventions for OneCare and OneCare Connect monitored the outreach efforts for HRA collection, both initial and annual. The volume of HRAs sent to delegated networks was tracked and involved 100% oversight review of each bundle and the designation of a care management level. Additionally, when each bundle was returned, interventions demonstrate 100% review of each bundle with goal of this review being completed within 10-business days of receipt. Several regulatory measures were monitored for the OneCare Connect model: CA 1.5 Individualized Care Plan (ICP) completion for high and low risk members; CA 1.6 documentation of care goal discussion; and Medicare-Medicaid (MMP) 3.2 Members with ICP completed in 90 days of enrollment. Finally, members in Long-Term Care were identified and ensured to receive their HRAs according to the Model of Care.

Findings

Table A

Line of Business	Performance Area	Goal	Qtr Q1 2022	Qtr 2 2022	Qtr 3 2022
OneCare	HRA ***Initial Outreach***	95%	99%	100%	100%
	HRA ***Annual Outreach***	95%	100%	99%	100%
	Each HRA ***reviewed and sent*** for care plan development	90%	100%	100%	100%
	Each Care Plan bundle ***reviewed within 10 business days*** from bundle return	10 days; or 90%	Jan: 100% Feb: 100% Mar: 88%	Apr: 33% May: 20 days Jun: 25 days	Jul: 30days Aug: 17days Sep: Pending
OneCare Connect	HRA ***Initial Outreach***	95%	100%	100%	100%
	HRA ***Annual Outreach***	95%	99%	100%	100%
	Each HRA ***reviewed and sent*** for care plan development	90%	100%	100%	100%
	Each Care Plan bundle ***reviewed within 10 business days*** from bundle return	10 days; or 90%	Jan: 100% Feb: 94% Mar: 48%	Apr: 21% May: 30days Jun: 30days	Jul: 30days Aug: 17days Sep: 18days
Regulatory Monitoring	1.5 Care Plan - High risk	75%	85%	87%	89%
	1.5 Care Plan - Low risk	75%	78%	81%	83%
	1.6 Care Goal Discussion	95%	98%	99%	99%
	3.2 ICP Completion	85%	85%	81%	89%
LTC HRA	HRA Outreach Missing	0	3	7	0

Analysis

a. HRA outreach met the benchmarks for 2022 and is consistent with the 2021 data.

b. Health Network MOC Oversight tracks two variables. The benchmark for review of HRA and CML setting has met benchmarks for 2022 and is consistent with 2021 data. ICP review in a 10-business-day turnaround has not met benchmarks that were effectively met in 2021. This is an internal standard and not a regulatory standard. ICP bundles returned are being reviewed but at longer than expected interval and barriers are outlined below.

c. CA 1.5 had benchmark goal set and met for 2022 data.

d. CA 1.6 members with an ICP and care goal discussion is a withhold measure and benchmark of 95% has been met for 2022 and is consistent with 2021 data.

e. MMP 3.2 newly eligible members with ICP completed in 90 days of enrollment is also a withhold measure with benchmark of 85% and is on track to be met for 2022. Data is consistent with 2021.

f. LTC HRA monitoring on quarterly basis to confirm members flagged as LTC are outreached for the HRA process. This was new monitoring and feedback provided in Q1 and Q2. Q3 has demonstrated this new monitoring and process change as all LTC members received HRA outreach in Q3. All members from Q1 and Q2 have since been outreached to for the HRA process.

Barriers

a. There are multiple factors that have lengthened turnaround times for ICP review. One barrier surrounds the medical management system and changes made to file-listening process in March 2022. The changes prevented or delayed access and visibility by oversight to the ICP files needing review. Ongoing technical issues led to challenges in receiving files.

b. New processes implemented for members who either declined or where unable to be contacted for HRA. This group of members now require review for a data ICP and a CML setting. This evaluation is prioritized above review of returned ICP files. The prioritization of HRAs amplified in May 2022 when DHCS expanded Medi-Cal eligibility.

Opportunities for Improvement

a. Case Management's oversight role and function will be restructured and implemented in phases. The first phase was implemented in November 2022 and will continue into 2023. Improvement efforts for 2022 oversight benchmarks are tempered with this awareness. The Model of Care (MOC) tracking file was modified for OneCare and OneCare Connect in November 2022. Health Networks submitted a revised MOC tracking file that contained additional data fields to ensure compliance with MOC. For 2023, restructuring of oversight will occur in which a select number of members will be reviewed allowing for improved efficiencies, minimizing technical challenges, and alignment of audit and oversight practices.

Behavioral Health

Applied Behavior Analysis Pay for Value Performance Program

The Applied Behavior Analysis (ABA) is a type of Behavioral Health Treatment (BHT) serviceI, It is a Medi-Cal covered service under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for members under 21 years of age. ABA therapy is intense, with treatment hours averaging 9 to 10 per week. It has been identified as an evidenced-based approach for preventing or minimizing the adverse effects of behaviors that interfere with learning and social interaction. The course of treatment can last for several years or longer. Most of the direct services are rendered by paraprofessionals who are unlicensed and require ongoing supervision. Since DHCS implemented the BHT benefit in 2014, CalOptima Health has followed the State Plan Amendment (SPA 14-026) regarding the types of providers allowed to supervise paraprofessionals:

- Board Certified Behavior Analyst (BCBA)
- Behavior Management Consultant (BMC)
- Behavior Management Assistant (BMA)
- Board Certified Assistant Behavior Analyst (BCaBA)

The BCBA and BMC are considered the top tier supervisor types, while BMA and BCaBA fall under the mid-tier level. When a paraprofessional is supervised by a mid-tier provider, a BCBA or BMC is still required to oversee the work to ensure quality of care. In 2018, CalOptima Health proposed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. The rationale for phasing out mid-tier was to raise the overall quality of care and align our approach with most commercial insurance plans and the Regional Center of Orange County. At that time, ABA providers expressed concerns over lack of available BCBAs and the associated cost. As a result, CalOptima Health has continued to maintain the 3-Tier model approach.

In 2019, DHCS conducted a medical audit. The file review showed some ABA providers were not providing the hours as stated in individual members' treatment plans. DHCS noted that when ABA providers insufficiently deliver direct service hours, members may not receive effective treatment and consequently, the quality of care may be compromised.

ABA P4V Performance Metrics

To improve the quality of ABA services, Behavioral Health Integration (BHI) addressed the quality issues by implementing an ABA Pay for Value (P4V) program starting January 1–December 2021 and received Board of Directors approval to extend the program through December 31, 2022. The program was designed to incentivize ABA provider groups who demonstrate improvement in supervision hours and utilization of one-on-one (1:1) services. There are no HEDIS or standardized measures for the quality of ABA services. Two performance metrics were proposed and approved by the Board of Directors:

- Applied Behavor Analysis Hours (ABAH) - ABA Supervision Hours termed as the percentage of supervision hours completed by a BCBA or BMC
- Applied Behavor Analysis Utilization (ABAU) - ABA Utilization is termed as the percentage of 1:1 hours utilized vs. authorized

To establish a baseline period for the performance metrics, claims data from January 1–December 31, 2020, was used. However, if an ABA provider group did not have an established 2020 baseline rate, 2021 claims data were used to establish their baseline. The ABA provider group had to reach the metric targeted goal percentage/rate to receive an incentive payment. The payments were set at four incentive tier levels and were no more than 4% of the provider group's annual claims.

Incentive Tier Levels	1	2	3	4
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

a. ABAH Metric – goal is to obtain 50% or higher to receive an incentive payment

Incentive Tier Levels	1	2	3	4
Metric Target Goal	50.00%	65.00%	80.00%	95.00%

b. ABAU Metric – goal is to obtain a higher percentage than the baseline rate

			1	**2**	**3**	**4**
Baseline rate			**Metric Target Goal**			
70%	and	up	72.50%	75.00%	77.50%	80.00%
65%	to	69%	68.75%	72.50%	76.25%	80.00%
60%	to	64%	65.00%	70.00%	75.00%	80.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%
50%	to	54%	57.50%	65.00%	72.50%	80.00%
45%	to	49%	53.75%	62.50%	71.25%	80.00%
40%	to	44%	50.00%	60.00%	70.00%	80.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%

c. Example

	ABAH	ABAU
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	0.50% (tier level 1)	0.50% (tier level 1)
Provider qualifies for a total of 1% incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

Program Analysis

	CY 2020 (Baseline)	Program Year 1 CY 2021 (Measurement period)	Program Year 1 CY 2022 (Measurement period)
Metric ABAU	56.1%	56.6%	TBD
Metric ABAH	51.7%	50.4%	TBD

- 94 ABA provider groups were eligible to participate in the program; 73 of the 94 (78%) received an ABA P4V incentive payment.
- The 1:1 utilization rate for 2021 was 56.6% and the BCBA/BMC Supervision rate for 2021 was 50.4%. The incentive payout for year 2021 was $621,980.28.
- For 2021, metric percentages were calculated by looking at authorizations completed in 2021. Due to the limitations of utilizing 6-month authorization claims data with services still occurring, the same logic was applied to the 2022 program year.

Program Barriers

- The supervision metric addressed a concern since the start of CalOptima Health's ABA program. At that time, CalOptima Health met with ABA provider groups, and it was agreed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. Approximately 50% of supervisions were conducted by the mid-tier level supervisors, which all providers agreed was not ideal.
- The rationale for phasing out mid-tier level supervisors was to raise the overall quality of care provided to members, align our approach with commercial insurance plans and the Regional Center of Orange County. This did not happen as quickly as was expected, perhaps due to the unexpected increase in the members receiving ABA.

Opportunities for Improvement

The program will end December 31, 2022. For 2022, the metrics performance will be evaluated, reported and ABA provider groups incentive payments will be issued in Q2 2023.

Behavioral Health Integration Incentive Program (BHIIP)

DHCS initiated a statewide BHIIP funded under Proposition 56 (excise tax rate increase on cigarettes and tobacco products). The primary objectives of the program were to incentivize MCPs to improve physical and behavioral health outcomes, care delivery efficiency and patient experience, and to establish or expand fully integrated care in their network. CalOptima Health summoned interested network provider groups to complete a BHIIP application identifying which of the six DHCS-approved project/project options they would choose to build an infrastructure to meet the objectives of the program. CalOptima Health submitted the applications to DHCS, and seven provider groups representing Federally Qualified Health Centers (FQHCs) and a behavioral health provider were approved by DHCS to participate in the program. The BHIIP was targeted to begin on April 1, 2020, however, due to COVID-19, the program's start date was delayed. In November 2020, DHCS announced that CalOptima Health had been approved to implement its BHIIP starting January 1, 2021, and continue through December 31, 2022. CalOptima Health's responsibility is/was to oversee the provider groups' project performance and issuance of the incentive payments for their project's completed milestones. CalOptima Health continues to be eligible to earn a total incentive payment of up to $13.2 million. This amount includes:

- $2.5 million earnable once the approved selected provider groups signed their Memorandums of Understanding (MOUs)
- $5.3 million earnable for achievement of Project Milestones in Program Year 1 (January 1, 2021–December 31, 2021)
- $5.3 million earnable for achievement of Project Milestones in Program Year 2 (January 1, 2022–December 31, 2022)

BHIIP Project Options

a. Basic Behavioral Health Integration (Project Option Identifier 3.1)

- Population Goal — Improve evidence-based medical and behavioral health integration practices with a primary care, specialty care or behavioral health provider's office or clinic. This package is best suited for practices that are new to behavioral health integration.

b. Maternal Access to Mental Health and Substance Use Disorder (SUD) Screening and Treatment (Project Option Identifier 3.2)

- Population Goal — Increase prenatal and postpartum access to mental health and substance use disorder screening and treatment.

c. Medication Management for Beneficiaries with Co-Occurring Chronic Medical and Behavioral Diagnoses (Project Option Identifier 3.3)

- Population Goal — Improve evidence-based behavioral health prescribing and management of psychotropic, opioid use disorder (OUD), and alcohol use disorder medications.

d. Diabetes Screening and Treatment for People with Serious Mental Illness (SMI) (Project Option Identifier 3.4)

- Population Goal — Improve health indicators for patients with both diabetes and serious mental illness.

e. Improving Follow-Up After Hospitalization for Mental Illness (Project Option Identifier 3.5)

- Population Goal — Improve timely follow up after hospitalization for mental illness.

f. Improving Follow-Up After Emergency Department Visit for Behavioral Health Diagnosis (Project Option Identifier 3.6)

- Population Goal — Improve timely follow-up after emergency department visit for mental illness and substance use disorder.

3. CalOptima Network Provider Groups Approved by DHCS to Participate in the BHIIP

- Families Together of Orange County
- KCS Health Center
- Providence St. Joseph Heritage Healthcare
- North Orange County Regional Health Foundation
- Share Our Selves
- Southland Integrated Services Inc.
- Harbor Psychiatry and Mental Health

4. CalOptima Provider Groups and Approved Selected Project Option(s)

Provider Group	Project Options					
	3.1	3.2	3.3	3.4	3.5	3.6
Families Together of Orange County		X	X	X		
Harbor Psychiatry and Mental Health					X	
KCS Health Center			X			X
North Orange County Regional Health Foundation	X					
Providence St. Joseph Heritage Healthcare (#225)	X					
Share Our Selves	X					
Southland Integrated Services Inc.	X			X	X	

Findings

- Due to the delayed start of BHIIP, provider groups were not able to establish a 2020 baseline prior to the start of the program. CalOptima Health received approval from DHCS to have Program Year 1 2021 act as the baseline year and Program Year 2 2022 to act as the measurement year.
- As of Q3 2022, six of the seven provider groups continue to participate in the program and are submitting their project milestones and supporting documentation quarterly as directed.
- By Q2 2022, CalOptima Health has invoiced and received payments in the amount of $5.2 million (97% of the eligible funding) from DHCS for Program Year 1 2021 and $2.3 million for Program Year 2 2022. These payments are used to incentivize the provider groups for completing their quarterly milestones as outlined in their MOUs.
- Due March 31, 2023, CalOptima Health will submit an annual report to DHCS showing the program performance measure results for the 2022 measurement year.

Analysis

- Each BHIIP provider group is required to submit a quarterly milestone reporting template listing the projects anticipated quarterly milestones and its associated payment as identified in their MOU(s). The provider group must provide documentation supporting the milestone's completion.
- Milestone completion rate for Program Year 1 — 91%

Barriers

Due to the delayed start of BHIIP, during late 2021, one of the provider groups was unable to establish the required infrastructure to support their selected project, therefore, they were unable to complete the project's quarterly milestones and opted out of the program per DHCS guidance.

Opportunities for Improvement

The program ends December 31, 2022; however, the provider groups are encouraged to maintain the enhancements, health programs and patient experience activities they have deployed during the BHIIP operations duration.

Student Behavioral Health Incentive Program (SBHIP)

As a component of the Child and Youth Behavioral Health Initiative (CYBHI) and in accordance with State law AB 133, Welfare & Institutions Code Section 5961.3, DHCS designed the SBHIP to support early identification and treatment through school-affiliated behavioral health services and reduce progression to serious mental illness and substance use disorders (SUDs). The program has a statewide funding allocation of $389 million designated over a three-year period January 1, 2022–December 31, 2024. The program will provide incentive payments when SBHIP goals and metrics are met by CalOptima Health. Increasing the coordination among Local Education Agencies (LEAs), behavioral health community services and the county mental health plan agency will significantly impact the delivery systems.

The SBHIP goals and metrics are associated with targeted interventions approved by DHCS to increase access for preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK–12 children in public schools. Developing partnerships between LEAs and community resources will create a comprehensive and continuous system of care for Medi-Cal students to access the entire scope of available benefits consistent with the national movement of increasing access to Medicaid services in schools.

SBHIP Goals

- Break down silos and improve coordination of child and adolescent student behavioral health services through increased communication with schools, school-affiliated programs, managed care providers, counties and mental health providers.
- Increase the number of TK–12 students enrolled in Medi-Cal receiving behavioral health services through schools, school-affiliated providers, county behavioral health departments and county offices of education.
- Increase non-specialty services on or near school campuses.
- Address health equity gaps, inequalities and disparities in access to behavioral health services.

SBHIP Performance Outcome Metrics

a. Performance Outcome Metric #1: Increase access to behavioral health services (capacity, infrastructure, sustainability, behavioral health service) for Medi-Cal beneficiaries on or near campus

b. Performance Outcome Metric #2: Increase access to behavioral health services (capacity, infrastructure, sustainability, behavioral health service) for Medi-Cal beneficiaries provided by school-affiliated behavioral health providers

SBHIP Partners

All 29 Orange County school districts will be participating in SBHIP.

SBHIP Targeted Interventions

- Behavior Health Screenings and Referrals: Enhance Adverse Childhood Experiences and other age and developmentally appropriate behavioral health screenings to be performed on or near school campuses, and build out referral processes in schools (completed by behavioral health provider), including when positive screenings occur, providers taking immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) on or near school campuses and ensuring access or referral to further evaluation and evidence-based treatment, when necessary.
- Building Stronger Partnerships to Increase Access to Medi-Cal Services: Build stronger partnerships between schools, MCPs and county behavioral health plans so students have greater access to Medi-Cal covered services. This may include providing for technical assistance, training, toolkits, and/or learning networks for schools to build new or expand capacity of Medi-Cal services for students, integrate local resources, implement proven practices, ensure equitable care and drive continuous improvement.
- Technical Assistance Support for Contracts: Medi-Cal managed care plans execute contracts with county behavioral health departments and/or schools to provide preventive, early intervention and behavioral health services. It is expected that this targeted intervention would go above and beyond the MOU requirement.
- Technology Enhancements for Behavioral Health Services: Implement information technology and systems for cross-system management, policy evaluation, referral, coordination, data exchange, and/or billing of health services between the school and the MCP and county behavioral health department.

PSBHIP Funding Allocation and Targeted Intervention Incentive Payments

- DHCS has allocated $25 million to Orange County, representing 29 LEA/school districts within the county. Incentive payments will be dispersed by DHCS based on the completion of all DHCS SBHIP requirements.
- CalOptima Health may earn up to 20% of the maximum allocation for each targeted intervention. The remaining 20% may be earned for one additional targeted intervention or be divided among the targeted interventions as deemed appropriate by the MCP.
- Each targeted intervention is capped at 40% of the maximum allocated.

Program Year 1 – 2022: Required Program Deliverables and Due Dates

Deliverable	Due Date	Description

Needs Assessment Package	12/31/2022	Stakeholder Meetings Attestation Data Collection Strategy Needs Assessment Template LEA and Community Resource Map LEA and External Referral Process
Project Plans	12/31/2022	Project Plan(s) outlined for each Targeted Intervention(s).
Receive funding allocation for approved 2022 deliverables	04/2023	Needs Assessment: Up to 50% of Assessment allocation Project Plan: 50% of the Targeted Intervention allocation

Performance Outcomes

Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)

Cervical Cancer Screening (CCS)

A hybrid HEDIS[1] and MCAS[2] measure, Cervical Cancer Screening (CCS) measures the percentage of women ages 21–64 who received one or more screening tests for cervical cancer during or within the three years prior to the measurement year, or five years for women ages 30–64 with HPV co-testing.

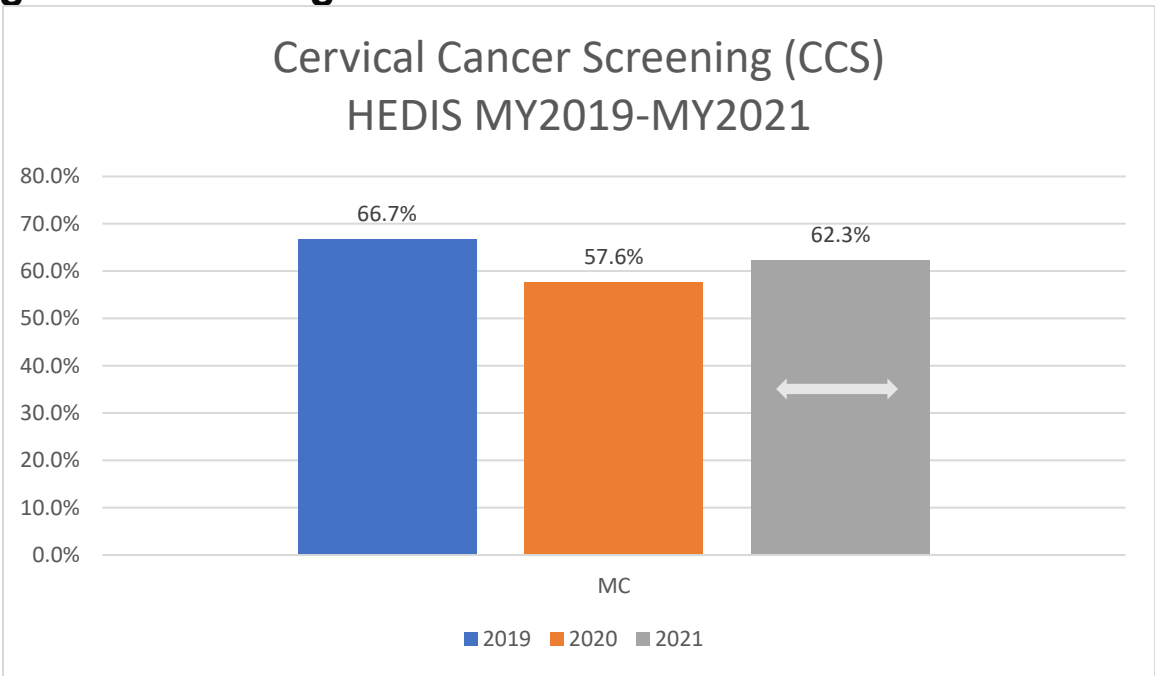
Interventions

The 2021 CCS member health reward was promoted through the CalOptima Health website, member newsletters, electronic newsletters and provider newsletters.

Findings

Figure 1 below compares CalOptima Health Medi-Cal CCS rates for HEDIS MY 2019–MY2021. The rate increased by 4.7 percentage points from the prior year but there is statistically no difference between MY 2020 to MY 2021. The rate met the minimum performance level (MPL) and the internal goal of 59.12% by 3.2 percentage points (Table 1).

CCS Figure 1: Trending HEDIS Rates MY 2019–MY 2021 Results: MC



CCS hybrid rate shown. ↓↑ statistically higher or lower ↔ statistically no difference

CCS Table 1: CCS Measure Medi-Cal Percentiles, Goal and Report Requirements

HEDIS Measure		**Percentile, Goal, Reporting Requirements**				
HEDIS MY 2021	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*	*Goal*	*Goal Met/Not Met*	*Reporting Requirements***
Cervical Cancer Screening (CCS)	54.01%	61.08%	67.99%	59.12%	Met	HPR, *MPL, P4V

*MPL met ++ *measure triple weighted for Health Plan Ratings* **HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value.*

Table 2 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative HEDIS MY 2021 rate (n=170,402) population. Race/Ethnicity rates that fell below MPL of 59.12% for Hispanic, White, No Response, Other, Korean, Black, Filipino, Chinese, and Asian/Pacific Islander population. The lowest rate was for members that identified as Other (39.86%) followed by members who identified as Korean (42.27%). Vietnamese members have the highest rates at 65.65% and met the 75th percentile (63.66%) followed by Hispanic members 57.05%.

CCS Table 2: Medi-Cal Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	*Hispanic*	*White*	*Vietnamese*	*No Response*	*Other*	*Korean*	*Black*	*Filipino*	*Chinese*	*Asian/Pacific Islander*
Numerator	34,256	17,023	17,359	13,238	2,786	1,797	1,582	1,455	975	963
Denominator	60,041	34,961	26,443	23,966	6,989	4,251	3,150	2,947	2,245	2,036
Rate	57.05%	48.69%	65.65%	55.24%	39.86%	42.27%	50.22%	49.37%	43.43%	47.30%
KPI (QC 50th %= 59.12%)*	Not Met	Not Met	Met 75th	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met

*Top 10 race/ethnicity by denominator count. *Medicaid Quality Compass MY2020 50th percentile.*

Table 3 examines rates by age groups for the administrative HEDIS MY 2021 rate (n= 170,402) population. Age groups that fell below MPL of 59.12% were 21–30, 31–44 and 60–64. The lowest rate was for members in age category 21–30 (45.79%) followed by members in age category 60–64. Members in age category 45–59 have the highest rates at 60.07% and met 50th percentile (59.12%)

CCS Table 3: Medi-Cal Administrative HEDIS MY 2021 Rate by Age

Admin	Age Group				
HEDIS MY 2021	*21–30*	*31–44*	*45–59*	*60–64*	*Grand Total*
Numerator	20,368	31,397	31,718	9,526	93,009
Denominator	44,482	55,411	52,801	17,708	170,402
Rate	45.79%	56.66%	60.07%	53.79%	54.58%
KPI (QC 50th %= 59.12%)*	Not Met	Not Met	Met 50th	Not Met	Not Met

*Medi-Cal CCS administrative rate by age group. *Medicaid Quality Compass MY 2020 50th percentile.*

a. CCS Member Health Reward

- CCS health reward mailing was not conducted for MY 2021. There was a decrease in the number of member health rewards submissions from 1,165 in MY 2020 to 555 in MY 2021 (Table 4).

CCS Table 4: 2021 Cervical Cancer Screening Member Health Reward

Forms Received	HEDIS Qualified	HEDIS Denominator*	HEDIS Eligible Participation Rate
555	458	169,047	0.27%

*The HEDIS administrative denominator was used to calculate the participation rate. * Medi-Cal HEDIS denominator dual eligible beneficiaries are removed.*

Analysis

There was a total of 555 CCS health reward submissions with 533 approved to receive the $25 gift card. Of the 555 health reward submissions, 458 CCS health reward form submissions remained in the CCS measure denominator and 445 were approved to receive the gift card. The health reward participation rate for the HEDIS MY 2021 CCS measure was 0.27% (458/169,047).

Barriers

- Members may not be able to complete cervical cancer screening because of lack of general knowledge about the test itself or the physical or psychological discomfort associated with the screening.
- Members may also have a fear about the test and test results and avoid getting screened.
- Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. Approximately 12% of members who remained unscreened at the end of MY 2021 had a history of previously completing a cervical cancer screening.
- There was no direct mailing to members about the CCS health reward mailing in MY 2021, which resulted in a low participation rate.
- The member health reward form requires a signed/stamped attestation by the provider performing the CCS. This may prevent some members from participating in the CCS health reward.
- Providers may be unaware of members who are due for CCS.
- Provider offices may not have the capability of in-office screening and must refer members to specialists.
- Continued hesitancy of going into the medical office for preventive screenings like CCS continuthe es due to COVID-19 pandemic, which may have also affected member submissions of the health reward forms.

5. Opportunities for Improvement

CCS Table 5: MY 2022 Medi-Cal CCS Prospective Rate Results

September 2021		**September 2022**		
Denominator	*Rate*	*Denominator*	*Numerator*	*Rate*
172,335	52.48%	191,605	98,507	51.41%

Claims/Encounters processed through September 2022

- As of September 2022, the CCS prospective rate was 51.41%, which is lower than the September 2021 prospective rate of 52.48% by 1.07 percentage points (Table 5).
- The hybrid CCS measure reached MPL in MY 2021. The new national benchmark was released in September 2022 and the MPL has decreased from 59.12% to 57.64%. Opportunity remains to increase the hybrid CCS measure to the pre-pandemic level of MY 2019 of 66.7%. The measure should continue to be a high priority for quality initiatives and member engagement.
- In MY 2022, member engagement initiatives that were placed on hold, due to the COVID-19 pandemic and Telephone Consumer Protection Act (TCPA), resumed. These included member reminders and enhanced promotion of the CCS member health rewards. Multiple modes of communication, including direct member mailing, Interactive Voice Response (IVR) campaigns, passive social media posts, and a mobile texting campaign, were performed. The multiple methods of communication will continue in MY 2023.
- At the conclusion of MY 2021, the Population Health Management department identified the top cities and languages for unscreened members who were due for CCS. In collaboration with the

Communications department, this information was used in MY 2022 to develop a digital ad campaign and paid social media campaign in English, Spanish and Vietnamese. These campaigns will continue in MY 2023.

- Additional mass media efforts that began in MY 2022 and will continue for MY 2023. They included radio ads in Spanish and Vietnamese and television ad campaigns on Public Broadcasting Service (PBS).
- Messaging will be more targeted for members previously screened and members will be provided with health education about the frequency of each screening.
- Target higher-risk members with health inequities caused by age or race. For the Medi-Cal population, when examining the top three race/ethnicity groups, White members have the lowest rate of screening as compared with Hispanic and Vietnamese members. In addition, we see that women ages 21–30 are less likely to be screened than women ages 31–44 and women ages to 45–59.
- Continue the CCS member health reward through 2023 to allow more time for members to become aware of the reward, and to improve promotion and member engagement efforts.
- Promote the CCS health reward among providers to increase participation in the program and motivate members to schedule and complete their cervical cancer screening. Have greater direct collaboration with CCN providers and health network quality teams.
- CalOptima Health will retain CCS on the 2023 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization by conducting multicomponent interventions to increase demand for cervical cancer screening.

Colorectal Cancer Screening (COL)

A hybrid HEDIS measure, Colorectal Cancer Screening (COL), measures the percentage of members ages 50–75 who had appropriate screening for colorectal cancer, which includes either fecal occult blood test (FOBT) during the measurement year, a flexible sigmoidoscopy during the past five years, or a colonoscopy within the past 10 years.

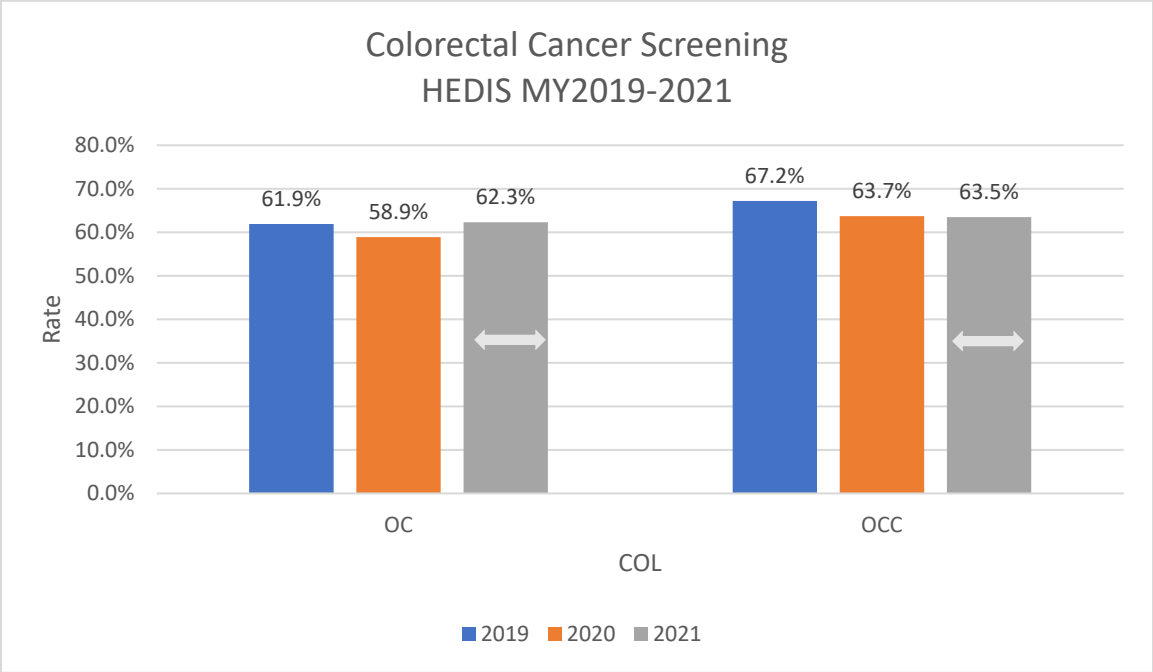
Interventions

From 1/1/2021 to 12/31/2021, CalOptima Health offered a $50 gift card to eligible CalOptima Health OneCare and OneCare Connect members who completed a sigmoidoscopy or colonoscopy between January to December 2021. The 2021 COL member health reward was promoted through the CalOptima Health website, member newsletters, electronic newsletters, provider newsletters and member mailings.

Findings

Figure 1 below compares CalOptima Health COL rates for HEDIS MY 2019–MY 2021 by line of business. The MY 2021 COL hybrid rate for OneCare (OC) was 62.3% (Figure 1). The rate increased by 3.4 percentage points from the prior year but was statistically no difference between MY 2020 to MY 2021. The rate met the projected 3-Star and the internal goal of 62% by 0.3 percentage points (Table 1). The MY 2021 rate for OneCare Connect (OCC) was 63.5%. The rate decreased by 0.2 percentage points from the prior year but was statistically no different between MY 2020 to MY 2021. The rate met the projected 3-Star and the internal goal of 62% by 1.5 percentage points (Table 1).

COL Figure 1: Trending HEDIS Rates MY 2019–MY2021 Results: OC, OCC



COL Hybrid Rate Shown ↓↑ statistically higher or lower ↔ statistically no difference

COL Table 1: COL Measure OC and OCC Percentiles, Goal and Report Requirements

HEDIS Measure		**Percentile, Goal, Reporting Requirements**				
HEDIS MY2021	*Projected 3-Star***	*Projected 4-Star***	*Projected 5-Star***	*Goal*	*Goal Met/Not Met*	*Reporting Requirements***
OC Colorectal Cancer Screening (COL)	62%	71%	80%	62%	Met	Star
OCC Colorectal Cancer Screening (COL)	62%	71%	80%	62%	Met	Star, P4V

***Star cut points are previous year*

OneCare: Table 2 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare HEDIS MY 2021 rate (n=1,338) population. Race/ethnicity rates that fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02% for White, Hispanic, No response, Vietnamese, Other, Filipino, Black, and Asian Indian members. The lowest rate is for members that identified as Other (40.00%) but this group has a low denominator count. The lowest rate with substantial denominator count (n > 100) is for Vietnamese members (44.53%). Asian/Pacific Islander members have the highest rate at 84.62% followed by Chinese members at 80.00% but both groups have a low denominator count. The highest rate with substantial denominator count (n>100) is for members who identified as No response (57.54%) followed by White members (55.08%).

COL Table 2: OneCare Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	White	Hispanic	No Response	Vietnamese	Other	Filipino	Black	Asian/ Pacific Islander	Asian Indian	Chinese
Numerator	271	211	103	61	14	19	13	11	6	8
Denominator	492	392	179	137	35	31	20	13	10	10
HEDIS Rates	55.08%	53.83%	57.54%	44.53%	40.00%	61.29%	65.00%	84.62%	60.00%	80.00%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met 90th	Not Met	Met 75th

*Top 10 race/ethnicity by denominator count. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

OneCare Connect: Table 3 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare Connect HEDIS MY 2021 rate (n= 6,439) population. Race/ethnicity rates that fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02% for Hispanic, White, No response, Vietnamese, Other, Asian/Pacific Islander, Black, Filipino and Unknown. The lowest rate was for No response (77.59%) followed by Asian/Pacific Islander members (52.84%). Chinese members have the highest rate at 78.69% followed by members identified as Unknown at 62.20% but both groups have a low denominator count. The highest rate with substantial denominator count (n>100) is for members that identified as Filipino (60.15%) followed by Hispanic members (59.10%).

COL Table 3: OneCare Connect Total HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	No Response	Vietnamese	Other	Asian/ Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	1,075	858	566	379	249	149	79	80	51	45
Denominator	1,819	1,578	1,079	708	429	282	140	133	82	58
Rate	59.10%	54.37%	52.46%	53.53%	58.04%	52.84%	56.43%	60.15%	62.20%	77.59%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met 75th

*Top 10 race/ethnicity by denominator count. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

OneCare: Table 4 examines age group rates for the administrative OneCare HEDIS MY 2021 rate (n=1,338). All age groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was for members in age category 75–99 (50.00%) but the category had a low denominator count. The lowest rate with substantial denominator count (n>100) is for age category 65–74 (52.85%). Members in age category 60–64 have the highest rates at 58.60%.

COL Table 4: OneCare Administrative HEDIS MY 2021 Rate by Age

Admin	Age Group				
HEDIS MY 2021	*50–59*	*60–64*	*65–74*	*75–99*	*Grand Total*
Numerator	135	109	482	1	727
Denominator	238	186	912	2	1,338
Rate	56.72%	58.60%	52.85%	50.00%	54.33%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met

*OneCare COL administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

OneCare Connect: Table 5 examines age groups rates for the administrative OneCare Connect HEDIS MY 2021 rate (n=6,439). All age groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was for members in age category 50–59 (51.39%). Members in age category 60–64 have the highest rate at 57.84%.

COL Table 5: OneCare Connect Administrative HEDIS MY 2021 Rate by Age

Admin	Age Group				
HEDIS MY 2021	*50–59*	*60–64*	*65–74*	*75–99*	*Grand Total*
Numerator	371	358	2,671	205	3,605
Denominator	722	619	4,743	355	6,439
Rate	51.39%	57.84%	56.31%	57.75%	55.99%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met

*Medi-Cal CCS administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

OneCare: Table 6 examines gender group rates for the administrative OneCare HEDIS MY 2021 rate (n=1,338). All gender groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was the male category (52.89%).

COL Table 6: OneCare Administrative HEDIS MY 2021 Rate by Gender

Admin	Gender		
HEDIS MY 2021	*Female*	*Male*	*Grand Total*
Numerator	398	329	727
Denominator	716	622	1,338
Rate	55.59%	52.89%	54.33%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met

*Medi-Cal CCS administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

OneCare Connect: Table 7 examines gender group rates for the administrative OneCare Connect HEDIS MY 2021 rate (n=6,439). All gender groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was the male category (54.59%).

COL Table 7: OneCare Connect Administrative HEDIS MY 2021 Rate by Gender

Admin	Gender		
HEDIS MY 2021	*Female*	*Male*	*Grand Total*
Numerator	1,986	1,619	3,605
Denominator	3,473	2,966	6,439
Rate	57.18%	54.59%	55.99%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met

*Medi-Cal CCS administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

a. COL Member Health Reward

The COL health reward mailing occurred in June 2021 to 310 OC HEDIS unscreened members and to 2,042 OCC HEDIS unscreened members who opted to receive CalOptima Health member mailing (Table 8). There was an increase in the number of member health rewards submissions from 0 in MY 2020 to 5 in MY 2021 for OC and 30 in MY 2020 to 42 in MY 2021 for OCC.

COL Table 8: MY 2021 Colorectal Cancer Screening Health Reward Mailing Campaign

Line of Business	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
OneCare	310	5	4	1,338	0.30%
OneCare Connect	2,042	42	35	6,439	0.54%

The HEDIS administrative denominator was used to calculate the participation rate.

Analysis

a. OneCare

   i. In June 2021, of the 310 members who were mailed the health reward form, 246 members remained in the denominator for the administrative HEDIS MY 2021 COL measure. Sixty-eight (68) members completed a COL screening after the mail drop date with a rate of 5.08% (68/1,338). Of the 5 COL health reward submissions, 4 COL health reward form submissions remained in the COL measure denominator. The health reward participation rate for the HEDIS MY 2021 COL measure was 0.30% (4/1,338).

b. OneCare Connect

   i. In June 2021, of the 2,042 members who were mailed the health reward form, 1,825 members remained in the denominator for the administrative HEDIS MY 2021 COL measure. A total of410 members completed a COL screening after the mail drop date with a rate of 6.36% (410/6,439). Of the 41 COL health reward submissions, 35 COL health reward form submissions remained in the COL measure denominator. The health reward participation rate for the HEDIS MY 2021 COL measure was 0.54% (35/6,439).

Barriers

- Members may not complete their colorectal cancer screening because of lack of general knowledge about the test itself or the physical or psychological discomfort associated with the screening.
- Members may also have a fear about the test and test results and avoid getting screened.
- Members are not aware of the multiple screening options that are available to them and the frequency of screening for each option. CalOptima Health currently does not offer member health incentive for completing colorectal cancer screening via a home testing kit, requiring the member to see a provider to get a test ordered/performed.
- Members may not be aware of the frequency of each screening type especially after having a previous screening with a negative result. For example, approximately 30% of OneCare members who remained unscreened at the end of 2021 had a history of previously completing a colorectal cancer screening.
- The member health reward form requires a signed/stamped attestation by the provider. This may prevent some members from participating in the program.
- The PCP may be unaware of assigned members who are due for COL screenings. PCP offices must refer members to a specialist to complete screening.
- Continued hesitancy of going into medical office for preventive screening like COL continues due to the COVID-19 pandemic, which may have affected member submission of the health reward forms.

Opportunities for Improvement

COL Table 9: MY 2022 OC and OCC COL Prospective Rate Results

Line of Business	September 2021		September 2022		
	Denominator	*Rate*	*Denominator*	*Numerator*	*Rate*
OneCare	1,280	47.50%	1,973	97391	46.68%
OneCare Connect	6,561	50.10%	6,790	3,566	52.52%

Claims/Encounters processed through September 2022

- As of September 2022, the COL OneCare prospective rate is at 46.68%, which is lower than the September 2021 prospective rate of 47.50% by 0.82 percentage points. The COL OneCare Connect prospective rate is at 52.52%, which is higher than the September 2021 rate of 50.10% by 2.42 percentage points (Table 9). On December 31, 2022, the OneCare Connect plan will end and members will transition to OneCare, which may impact rates going forward.
- The hybrid COL measure reached the projected 3 Star rating but did not meet the CMC Quality Compass MY 2020 50th percentile for both OneCare and OneCare Connect. The new national benchmark was released in October 2022 and the 50th percentile has decreased from 72.02% to 71.78%. Opportunity remains to increase the Hybrid COL measure above the pre-pandemic level of MY 2019 of 61.9% for OneCare and 67.2% for OneCare Connect. The COL measure will change in MY 2024 to only reporting via electronic clinical data systems (ECDS). The measure will continue to be a high priority for quality initiatives and member engagement.
- In MY 2022, CalOptima Health resumed member engagement initiatives that were placed on hold due to COVID-19 pandemic and Telephone Consumer Protection Act (TCPA). Member reminders and enhanced participation in the COL member health reward were conducted. Multiple modes of communication were used, including direct member mailing, IVR campaigns and passive social media campaigns. The multi-modes of communication will continue in MY 2023 with the addition of a texting campaign for the Medi-Cal population as the Medicaid product line was added to the administrative data collection method and the age range was revised from ages 50–75 to ages 45–75 in MY 2022.
- At the conclusion of MY 2021, the Population Health Management department identified the top cities andlanguagese for unscreened members due for COL. In collaboration with the Communication department, this information was used in MY 2022 to develop a digital and print ad campaign and paid social media campaign in English, Spanish and Vietnamese. These campaigns will continue in MY 2023.
- Messaging could be more targeted to members who were previously screened. In the messaging, CalOptima Health will include information about the screening options and frequency.
- Target higher-risk members with health iniquities caused by age, race or gender. In MY 2022, HEDIS added new data element tables for race and ethnicity stratification reporting to the COL measure. CalOptima Health will target higher-risk members due to health inequities caused by age or ethnicity. For OC and OCC populations, when examining ethnicity, White members had the lowest rate of screening when compared with other ethnic groups. In addition, members ages 65–75 are less likely to be screened than members ages 60–64.
- CalOptima Health will continue the COL member health reward through 2023 to allow more time for members to be aware of the health reward offered. In MY 2022, new rewards and incentive program regulations from CMS require offering rewards uniformly and without discrimination to all enrollees who qualify for the incentive's services; therefore, HEDIS measure age eligibility was removed from the health reward for OneCare and OneCare Connect.
- CalOptima Health will promote the COL health reward among providers to increase participation in the program and motivate members to schedule and complete their colorectal cancer screening. CalOptima Health will seek greater collaboration with CCN providers and health network quality teams.
- CalOptima Health will retain COL for the 2023 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communication.

Breast Cancer Screening (BCS)

The administrative HEDIS and MCAS measure, Breast Cancer Screening (BCS), measures the percentage of members who are women in the age range of 50–74 years, and have received one or more mammograms on or between October 1 two years prior to the measurement year and December 31 of the measurement year. Figure 1 below compares CalOptima Health BCS rates for HEDIS MY 2019–MY2021 by line of business.

Interventions

From 1/1/2021 to 12/31/2021, CalOptima Health offered a $25 gift to eligible Medi-Cal members ages 50–74 and OneCare and OneCare Connect members who completed a breast cancer screening mammogram between January to December 2021. The 2021 BCS member health reward program was promoted through the CalOptima Health website, member newsletters, electronic newsletters, provider newsletters and member mailings.

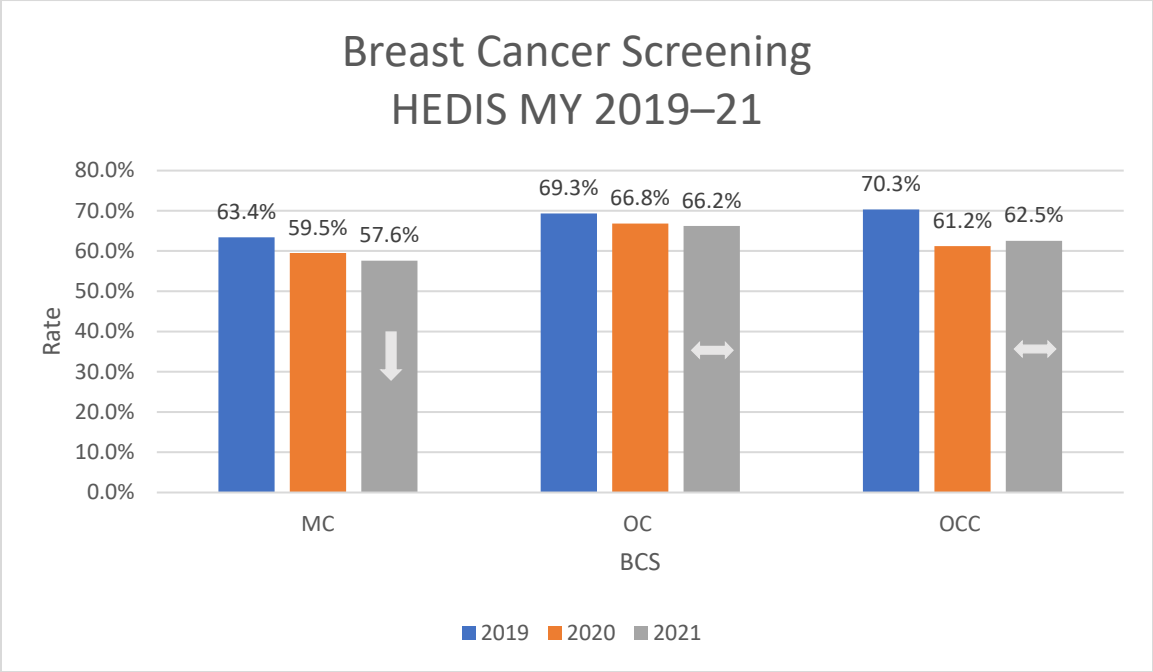
Findings

a. Medi-Cal: CalOptima Health's HEDIS MY 2021 BCS rate for Medi-Cal (MC) was 57.6% (Figure 1). The rate decreased by 1.9 percentage points from the prior year and was a statistically significant decrease between MY 2020 to MY 2021. The rate met the minimum performance level (MPL) of 53.93% but did not meet the internal goal of 61.24% (Table 1).

b. OneCare: CalOptima Health's HEDIS MY 2021 BCS administrative rate for OneCare (OC) was 66.2% (Figure 1). The rate decreased by 0.6 percentage points from the prior year but there was statistically no difference between MY 2020 to MY 2021. The rate met the projected 3-Star of 61% but did not meet the internal goal of 69% (Table 2).

c. OneCare Connect: CalOptima Health HEDIS MY 2021 BCS administrative rate for OneCare Connect (OCC) was 62.5% (Figure 1). The rate increased by 1.3 percentage points from the prior year but there was statistically no difference between MY 2020 to MY 2021. The rate met the projected 3-Star of 61% but did not meet the internal goal of 69% (Table 2).

BCS Figure 1: Trending HEDIS Rates MY 2019–21 Results: MC, OC, OCC



BCS Rate Shown ↓↑ statistically higher or lower ↔ statistically no difference

BCS Table 1: BCS Measure Medi-Cal Percentiles, Goal and Report Requirements

HEDIS Measure	**Percentile, Goal, Reporting Requirements**					
HEDIS MY 2021	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*	*Goal*	*Goal Met/Not Met*	*Reporting Requirements***
Breast Cancer Screening (BCS)	51.20%	56.72%	63.77%	61.24%	Not Met	HPR, ***MPL**, P4V

****MPL met** **HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

BCS Table 2: BCS Measure OC and OCC Percentiles, Goal and Report Requirements

HEDIS Measure	**Percentile, Goal, Reporting Requirements**					
HEDIS MY 2021	*Projected 3-Star***	*Projected 4-Star***	*Projected 5-Star***	*Goal*	*Goal Met/Not Met*	*Reporting Requirements***
OC Breast Cancer Screening (BCS)	61%	69%	76%	69%	Not Met	Star
OCC Breast Cancer Screening (BCS)	61%	69%	76%	69%	Not Met	Star, P4V

***Star cut points are previous year*

Medi-Cal: Table 3 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative Medi-Cal HEDIS MY 2021 rate (n= 43,983) population. Race/Ethnicity rates fell below MPL of 53.93% for White, Other, Chinese and Black population. The lowest rate was for members who identified as Chinese (46.71%) followed by members who identified as Other (47.05%). Vietnamese members have the highest rate at 66.03% followed by Hispanic members 60.94% and met the 90th percentile (63.77%) and the 75th percentile (58.70%), respectively.

BCS Table 3: Medi-Cal Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	**Race/Ethnicity**									
HEDIS MY2021	*Hispanic*	*Vietnamese*	*White*	*No Response*	*Other*	*Korean*	*Filipino*	*Asian/Pacific Islander*	*Chinese*	*Black*
Denominator	12,738	10,210	8,666	5,432	1,560	1,212	890	866	775	587
Numerator	7,762	6,742	4,119	3,162	734	663	520	476	362	293
HEDIS Rates	60.94%	66.03%	47.53%	58.21%	47.05%	54.70%	58.43%	54.97%	46.71%	49.91%
KPI (QC 50th % 53.93%)	Met 75th	Met 90th	Not Met	Met 50th	Not Met	Met 50th	Met 50th	Met 50th	Not Met	Not Met

*Top 10 race/ethnicity by denominator count. *Medicaid Quality Compass MY2020 50th percentile.*

Table 4 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare HEDIS MY 2021 rate (n= 668) population. Race/ethnicity rates that fell below CMC MY 2020 Quality Compass 50th percentile of 70.34% for Hispanic, White, Filipino, Other, Black, Asian Indian and Chinese members. The lowest rate is for Chinese members (50.00%) but this group has a low denominator count (n< 100). The lowest rate with substantial denominator count (n>100) is for White members (58.57%). Asian/Pacific Islander members have the highest rate at 85.71% followed by Vietnamese members at 78.26% but both groups have a low denominator count. The highest rate with substantial denominator count (n>100) is for Hispanic members at 68.89%.

BCS Table 4: OneCare Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	**Race/Ethnicity**									
HEDIS MY2021	*Hispanic*	*White*	*No Response*	*Vietnamese*	*Filipino*	*Other*	*Black*	*Asian/Pacific Islander*	*Asian Indian*	*Chinese*
Numerator	155	123	66	54	9	9	6	6	4	2
Denominator	225	210	93	69	17	14	11	7	6	4
HEDIS Rates	68.89%	58.57%	70.97%	78.26%	52.94%	64.29%	54.55%	85.71%	66.67%	50.00%
KPI (QC 50th % 70.34%)	Not Met	Not Met	Met 50th	Met 75th	Not Met	Not Met	Not Met	Met 90th	Not Met	Not Met

*Top 10 race/ethnicity by denominator count. *CMC benchmark from Quality Compass MY2020 50th percentile.*

OneCare Connect: Table 5 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare Connect HEDIS MY 2021 rate (=3,074) population. Race/ethnicity rates that fell below the CMC MY 2020 Quality Compass 50th percentile of 70.34% for Hispanic, White, No Response, Vietnamese, Other, Asian Pacific Islander, Black and Unknown. The lowest rate is for White members (52.17%) followed by members who did not respond to race/ethnicity (56.47%). Filipino members have the highest rate at 84.51% but this group has a low denominator count (n<100). The highest rate with substantial denominator count (n>100) is for Hispanic members at 69.29%.

BCS Table 5: OneCare Connect Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	**Race/Ethnicity**									
HEDIS MY 2021	*Hispanic*	*White*	*No Response*	*Vietnamese*	*Other*	*Asian/Pacific Islander*	*Black*	*Filipino*	*Unknown*	*Chinese*
Numerator	625	372	310	204	127	85	51	60	31	20
Denominator	902	713	549	299	194	139	73	71	45	27
HEDIS Rates	69.29%	52.17%	56.47%	68.23%	65.46%	61.15%	69.86%	84.51%	68.89%	74.07%
KPI (QC 50th % 70.34%)	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met 90th	Not Met	Met 50th

*Top 10 race/ethnicity by denominator count. *CMC benchmark from Quality Compass MY 2020 50th percentile.*

Medi-Cal: Table 6 examines rate by age group for the administrative Medi-Cal HEDIS MY 2021 rate (n= 43,983) population. All age groups reached MPL of 53.93%. The lowest rate was for members in age category 65–74 (55.67%) followed by members in age category 50–59 (57.46%). Members in age category 60–64 have the highest rate at 58.81% and met 75th percentile (58.70%).

BCS Table 6: Medi-Cal HEDIS MY 2021 Rate by Age

Admin	**Age Group**			
HEDIS MY 2021	*50–59*	*60–64*	*65–74*	*Grand Total*
Numerator	13,063	8,622	3,668	25,353
Denominator	22,734	14,660	6,589	43,983
Rate	57.46%	58.81%	55.67%	57.64%
KPI (QC 50th % 53.93%)*	Met 50th	Met 75th	Met 50th	Met 50th

*Medi-Cal BCS rate by age group. *Medicaid Quality Compass MY 2020 50th percentile.*

OneCare: Table 7 examines rate by age group for the administrative OneCare HEDIS MY 2021 rate (n= 668) population. Age groups that fell below MPL of 70.34% were 45–59 and 65–74. The lowest rate was for members in age category 65–74 (64.23%) followed by members in age category 50–59. Members in age category 60–64 have the highest rate at 78.16% and met 75th percentile (76.36%).

BCS Table 7: OneCare HEDIS MY 2021 Rate by Age

Admin	Age Group			
HEDIS MY 2021	*50–59*	*60–64*	*65–74*	*Grand Total*
Numerator	58	68	316	442
Denominator	89	87	492	668
Rate	65.17%	78.16%	64.23%	66.17%
KPI (QC 50th % 70.34%)*	Not Met	Met 75th	Not Met	Not Met

*OneCare BCS rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

OneCare Connect: Table 8 examines rate by age group for the administrative OneCare Connect HEDIS MY 2021 rate (n= 3,074) population. Age groups that fell below MPL of 70.34% were 45–59, 60–64 and 65–74. The lowest rate was for members in age category 50–59 (53.62%) followed by members in age category 65–74. Members in age category 60–64 have the highest rate at 63.77%.

BCS Table 8: OneCare Connect HEDIS MY 2021 Rate by Age

Admin	Age Group			
HEDIS MY 2021	*50–59*	*60–64*	*65–74*	*Grand Total*
Numerator	148	169	1,605	1,922
Denominator	276	265	2,533	3,074
Rate	53.62%	63.77%	63.36%	62.52%
KPI (QC 50th % 70.34%)*	Not Met	Not Met	Not Met	Not Met

*OneCare Connect BCS rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile*

BCS Health Reward

The BCS health reward mailing occurred in June 2021. The mailing was sent to 222 OC HEDIS unscreened members, 1,785 OCC HEDIS unscreened members, and in November 2021 to 1,069 HEDIS unscreened members that lived within 5 miles from a mobile mammography event location and who opted to receive CalOptima Health member mailings (Table 9). There was a decrease in the number of member health rewards submissions from 681 in MY 2020 to 454 in MY 2021 for MC. There was an increase in the number of member health rewards submissions from 3 in MY 2020 to 10 MY 2021 for OC and 72 in MY 2020 to 87 in MY 2021 for OCC.

BCS Table 9: MY 2021 Breast Cancer Screening Health Reward Mailing Campaign.

Line of Business	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
Medi-Cal*	1,069	454	242	40,247	0.60%
OneCare	222	10	10	668	1.50%
OneCare Connect	1,785	87	81	3,074	2.64%

*The HEDIS administrative denominator was used to calculate the participation rate. *Medi-Cal HEDIS denominator dual eligible beneficiaries are removed.*

Analysis

a. Medi-Cal

In November 2021, of the 1,069 members who were mailed the health reward form, 1,053 members remained in the denominator for the administrative HEDIS MY 2021 BCS measure. Three members completed a breast cancer screening after the mail drop date with a rate of 0.007% (3/40,247). Of the 454 BCS health reward submissions, 242 BCS health reward submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS MY 2021 BCS measure was 0.60% (242/40,247).

b. OneCare

i. In June 2021, of the 222 members who were mailed the health reward form, 181 members remained in the denominator for the administrative HEDIS MY 2021 BCS measure. Forty-two members completed a breast cancer screening after the mail drop date with a rate of 6.59% (42/668). Of the 10 BCS health reward submissions, 10 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS MY 2021 BCS measure was 1.50% (10/668).

c. OneCare Connect

i. In June 2021, of the 1,785 members who were mailed the health reward form, 1,582 remained in the denominator for the administrative HEDIS MY 2021 BCS measure. Two hundred eighty-two members completed a breast cancer screening after the mail drop date with a rate of 9.17% (282/3,074). Of the 87 BCS health reward submissions, 81 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS MY 2021 BCS measure was 2.64% (81/3,074).

Barriers

- Members may not complete their breast cancer screening because of a lack of general knowledge about the test itself or the physical or psychological discomfort associated with the the screening.
- Members may also have a fear about the test and test results and avoid getting screened.
- Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. For example, approximately 30% of Medi-Cal members who were unscreened in 2021 had a history of previously completing a mammogram.

- There was no large direct member mailing to Medi-Cal members about the BCS health reward in MY 2021, which resulted in low participation.
- The member health reward form requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the BCS health reward.
- PCPs may be unaware of the assigned members who are due for BCS. Members may be unable to schedule a timely appointment at an imaging center.
- Hesitancy of going into a medical office for preventive screenings continued due to the COVID-19 pandemic, which may have affected member submissions of the health reward forms.

Opportunities for Improvement

BCS Table 10: MY 2022 MC, OC and OCC BCS Prospective Rate Results

Line of Business	September 2021		September 2022		
	Den	*Rate*	*Den*	*Num*	*Rate*
Medi-Cal	44,821	50.82%	53,514	29,065	54.31%
OneCare	633	57.35%	1,001	616	61.54%
OneCare Connect	3,124	56.47%	3,200	1,983	61.97%

Claims/Encounters processed through September 2022

- As of September 2022, the BCS Medi-Cal prospective rate is 54.31%, which is higher than the September 2021 rate of 50.82% by 3.49 percentage points. The BCS OneCare prospective rate is 61.54%, which is higher than the September 2021 prospective rate of 57.35% by 4.19 percentage points. The BCS OneCare Connect prospective rate is at 61.97% which is higher than the September 2021 rate of 56.47% by 5.50 percentage points (Table 10). On December 31, 2022, the OneCare Connect plan ended and members transitioned to OneCare, which may impact the OneCare rate going forward.
- The BCS measure reached MPL in MY 2021. The new national benchmark for Medi-Cal was released in September 2021 and the MPL has decreased from 53.93% to 50.95%. The BCS measure reached the projected 3-Star rating but did not meet the CMC Quality Compass MY 2020 50th percentile for both OneCare and OneCare Connect. The new national benchmark for Medicare was released in October 2022 and the 50th percentile has decreased from 70.34% to 69.58%. In MY 2023, opportunity remains to increase the BCS measure to the pre-pandemic level of MY 2019 of 63.4% for MC, 69.03% for OC. In MY 2023, the BCS measure will transition to electronic clinical data systems (ECDS) only reporting,and the measure should continue to be a high priority for quality initiatives and member engagement.
- In MY 2022, CalOptima Health resumed member engagement initiatives that were placed on hold due to COVID-19 pandemic and Telephone Consumer Protection Act (TCPA). CalOptima Health conducted member reminders and enhanced participation in the BCS member health reward. Multiple modes of communication including direct member mailing, IVR campaigns, passive social media campaign, as well as the initiation of a texting campaign for Medi-Cal members-only were utilized.
- CalOptima Health also resumed community events in MY 2022. There were collaborative community events with CalOptima Health Community Network (CCN) mobile mammography vendors for the

purpose of informing CCN members of the importance of completing their mammogram. CalOptima Health will continue to promote mobile mammography community events to CCN members in MY2023.

- Mass media efforts, such as a television ad campaign on Public Broadcasting Service (PBS), which began in MY 2022, will continue in MY 2023.
- At the conclusion of MY 2021, the Population Health Management department identified the top cities and languages for unscreened members due for BCS. In collaboration with the Communication department, this information was used in MY 2022 to develop digital and print ad campaigns and paid social media campaigns in English, Spanish and Vietnamese. These campaigns will continue in MY 2023.
- Messaging could be more targeted for members previously screened and the frequency of screening could be provided.
- CalOptima Health will target higher risk members due to health iniquities caused by age or race. In MY 2023, HEDIS will add a new data element table for race and ethnicity stratification reporting to the BCS measure. For the MC, OC and OCC population, when looking at the top three race/ethnicity results, White members have the lowest rate of screening when compared with Hispanic and Vietnamese members. In addition, women ages 65–74 are less likely to be screened than women 60–64 years of age.
- CalOptima Health will continue the BCS health reward program through 2023 to allow more time for members to be aware of the health reward offered. In MY 2022, new rewards and incentive program regulation from CMS required to offer rewards uniformly and without discrimination to all enrollees who qualify for the incentive's services. As such, the HEDIS measure age eligibility was removed from the health reward for OneCare and OneCare Connect.
- CalOptima Health will promote the BCS health reward among providers and imaging centers to increase participation in the program. CalOptima Health will seek to improve direct collaboration with CCN providers and health network quality teams.
- CalOptima Health will retain BCS on the 2023 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communication.

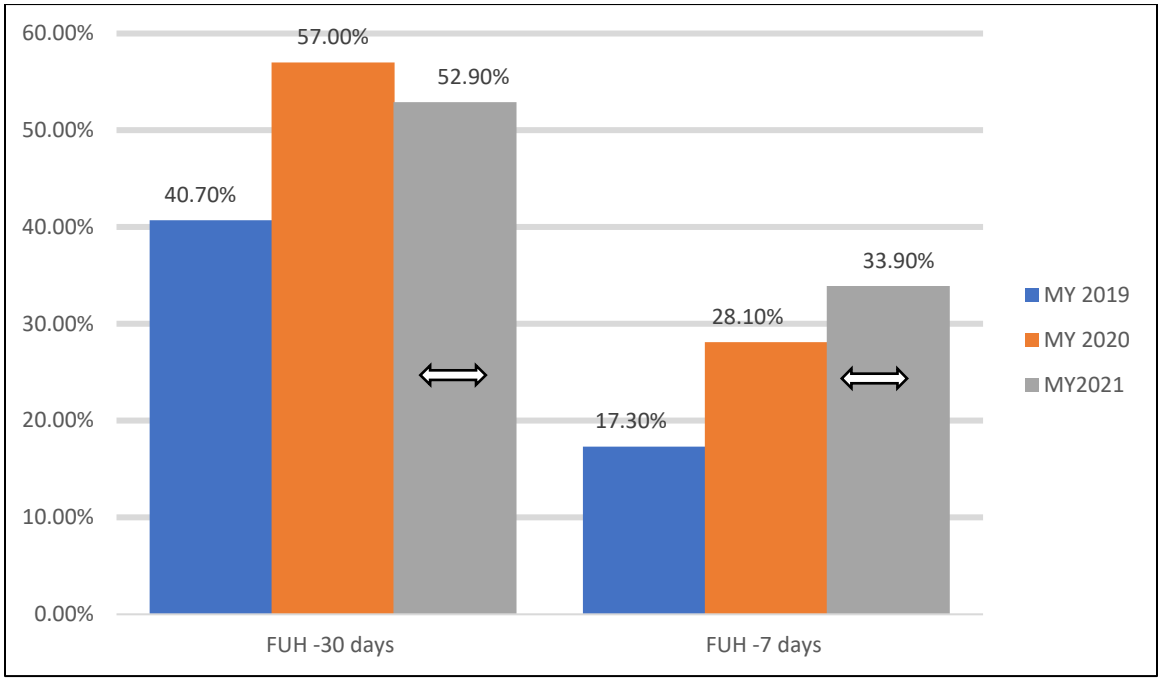
Follow-Up After Hospitalization for Mental Illness Within 7 and 30 Days of Discharge (FUH)

CalOptima Health's program assesses the percentage of discharges for members ages 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are measured in this program: the percentage of discharges for which the member received follow-up care within 30 days of discharge, as well as the percentage of discharges for the member who received follow-up care within 7 days after discharge.

Interventions

- The Transition of Care Management (TCM) team continued outreach to members post-discharge to coordinate follow-up appointments and address potential barriers (e.g., transportation). The team continued to build relationships with facilities, behavioral health (BH) providers, and county staff that further increased engagement.
- The TCM team continued weekly clinical round meetings to discuss concurrent reviews and internal coordination interventions.
- In January 2021, CalOptima Health launched the Behavioral Health Integration Incentive Program (BHIIP). The DHCS incentive program allowed plan providers to apply for various projects focused on improving health outcomes, care delivery efficiency and patient experience. Two provider groups were selected for the Improving Follow-Up After Hospitalization for Mental Illness project. In June, the Behavioral Health Integration (BHI) quality team attended a learning collaborative meeting. This meeting provided a discussion regarding successes and barriers for the providers focused on follow-up visits post-discharge.

Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After Hospitalization for Mental Illness (FUH) – 30 Days	41.22%	54.93%	73.03%	56.0%*	Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) – 7 Days ++	22.22%	34.67%	50.74%	34.67%	CMS

*=less than 3 - Star or 33rd percentile, ++ measure triple weighted for Health Plan Ratings, **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

Analysis

In 2021, CalOptima Health's Health Effectiveness Data Information Set (HEDIS) goal for OCC FUH-30 days was 56%; CalOptima Health fell short of the goal by 3.10 percentage points with a final rate of 52.90%. The goal for FUH-7 days was set at 34.67%. CalOptima Health missed this goal by 0.77 percentage points with a final rate of 33.90%. The 30-day follow-up decreased in 2021 by 4.10 percentage points from the previous year. We have continued to establish a significant upward pattern over the past few years in the 7-day follow-up appointments, which had an increase of 5.8 percentage points in 2021.

Barriers

- Due to invalid member contact information, the TCM team had difficulty in reaching members and were unable to assist with linkage or confirm follow-up appointments. This issue is especially true for those members experiencing homelessness.
- Rapid readmissions into the hospital after an initial discharge did not allow the TCM team a chance to outreach to some members, which resulted in a missed opportunity for appointment linkage.
- An increased number of members have declined assistance with Outpatient Behavioral Health appointment linkage.

Opportunities for Improvement

- The TCM team will continue to monitor and conduct post discharge outreach to ensure members are able to schedule and attend follow-up appointments.
- The BHI management team will visit additional hospitals with inpatient psychiatric units to discuss CalOptima Health's concurrent review and transition of care process and address any questions or concerns.
- The BHI management team will improve collaboration efforts with provider groups selected for the BHIIP project to improve follow-up after hospitalization.

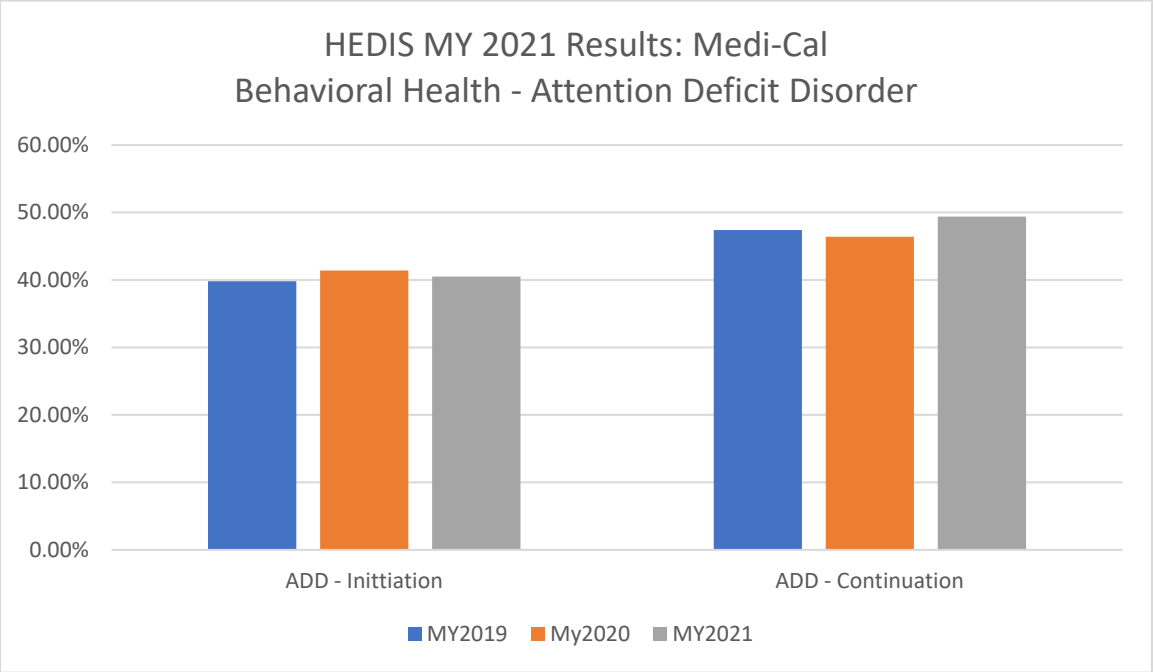
Follow-Up Care for Children with Prescribed ADHD Medication (ADD)

CalOptima Health's program monitors the percentage of children with newly prescribed attention-deficit/ hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period. The measure focuses on two phases. The Initiation Phase requires that the first follow-up visit occurs within 30 days of the initial ADHD medication being dispensed. The Continuation Phase includes those members who remained on medication for at least 210 days and attended at least two additional follow-up visits within nine months following the Initiation Phase.

Interventions

- The BHI Quality Team tracked providers who showed as noncompliant for follow-up visits with members. Providers with a high frequency of noncompliance were sent a letter to educate them on the ADD measure requirements and the importance of follow-up visits with members prescribed ADHD medications.
- The BHI Quality Team tracked members who filled an initial ADHD medication and conducted member outreach to ensure a 30-day follow-up appointment had been scheduled.
- The BHI Quality Team submitted an article for the Spring 2022 edition of CalOptima Health's member newsletter to educate on the importance of attending follow-up visits with a provider.

Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase	40.17%	47.74%	55.99%	44.51%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) – Continuation Phase	48.92%	60.35%	67.61%	55.96%	**HPR**

Analysis

CalOptima Health's 2021 HEDIS Initiation Phase final rate was 40.5%, which did not meet the intended goal of 44.51%. The 2021 HEDIS Continuation Phase final rate was 49.4%, which also did not meet the intended goal of 55.96%. The Initiation Phase has not demonstrated slight change over the past three years. The Continuation Phase has demonstrated slight change over the past three years.

Barriers

- The provider letter was faxed to the fax number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed.
- Due to the ongoing COVID-19 PHE, there was limited access to appointment scheduling in a timely manner for the member. This could be attributed to ongoing provider office staffing issues during the PHE.

Opportunities for Improvement

- The BHI Quality Team will continue to monitor providers not meeting the ADD requirements and conduct outreach efforts to provide education on the importance of follow-up visits with members prescribed ADHD medication.
- The BHI Quality Team will continue to explore opportunities for member outreach to remind families of the importance of attending follow-up visits and will work to identify barriers and assist members with appointment scheduling.
- ADD materials will be updated yearly and the team will distribute new materials to providers and members as part of the outreach effort.

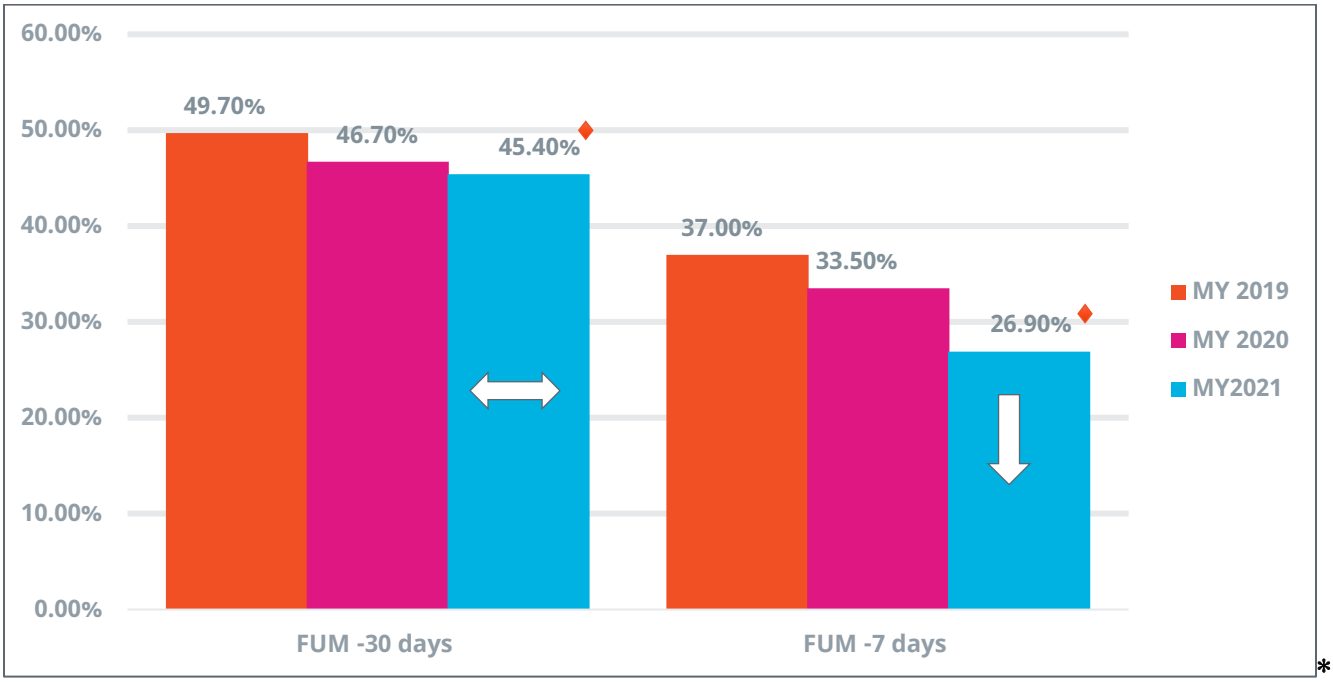
Follow-Up After Emergency Department Visit for Mental Illness (FUM)

CalOptima Health's program assesses the percentage of emergency department (ED) visits for members age 6 and older with a principal diagnosis of mental illness or intentional self-harm diagnoses and who had a follow-up visit for mental illness. Two rates are measured in this program, the percentage of ED visits for which the member received follow-up care within 30 days of ED visit, as well as the percentage of ED visits for which the member received follow-up care within 7 days of ED visit.

Interventions

- Measure identified as a Health Network (HN) Pay 4 Value (P4V) in MY 2022.
- BHI worked with Information Technology Services (ITS) to create an internal Tableau report to assist in identifying and analyzing potential trends in data (i.e., potential trends for health networks, ED facilities, members, providers, etc.).
- BHI participated in a pilot program to facilitate linkage to BH services post ED visits for a medical condition when a BH need is identified with a few of the local EDs in Orange County.

Findings



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HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After ED visit for Mental Illness (FUM) – 30 Days	48.41%	60.94%	74.39%	53.54%	
Follow-Up After ED visit for Mental Illness (FUM) – 7 Days ++	32.49%	46.38%	61.36%	38.55%	**HPR**

♦=less than 33rd percentile, ++ measure triple weighted for Health Plan Ratings, **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR = Health plan ratings, MPL= DHCS Minimum Performance Level, P4V= Pay for Value

Analysis

Findings reflect 2022 reporting year HEDIS Final Rates for MY 2021 data in table above. The BHI department began monitoring year-to-date rates in MY 2022.

Barriers

- The main barrier for the FUM measures has been obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. Through MY 2022, BHI had access to year-to-date rates from claims data.
- Scheduling appointments with mental health providers may have been challenging for members due to the ongoing pandemic.

Opportunities for Improvement

CalOptima Health recently began exploring opportunities with the vendor Collective Medical, which provides real-time data related to ED visits. With the ED visit data from Collective Medical, BHI will explore opportunities to conduct member outreach to engage and assist members in providing linkage and support in scheduling follow-up visits.

Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control

The HEDIS measure Comprehensive Diabetes Care (CDC): HbA1c Poor Control is part of the Medi-Cal Managed Care Accountability Set (MCAS), which is required to meet the minimum performance level (MPL) of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. CDC is defined as members ages 18–75 with diabetes (type 1 and type 2) who had a recent HbA1c level of >9.0% or who are missing a result, or if an HbA1c test was not done during the measurement year (lower is better).

CDC: HbA1c Poor Control

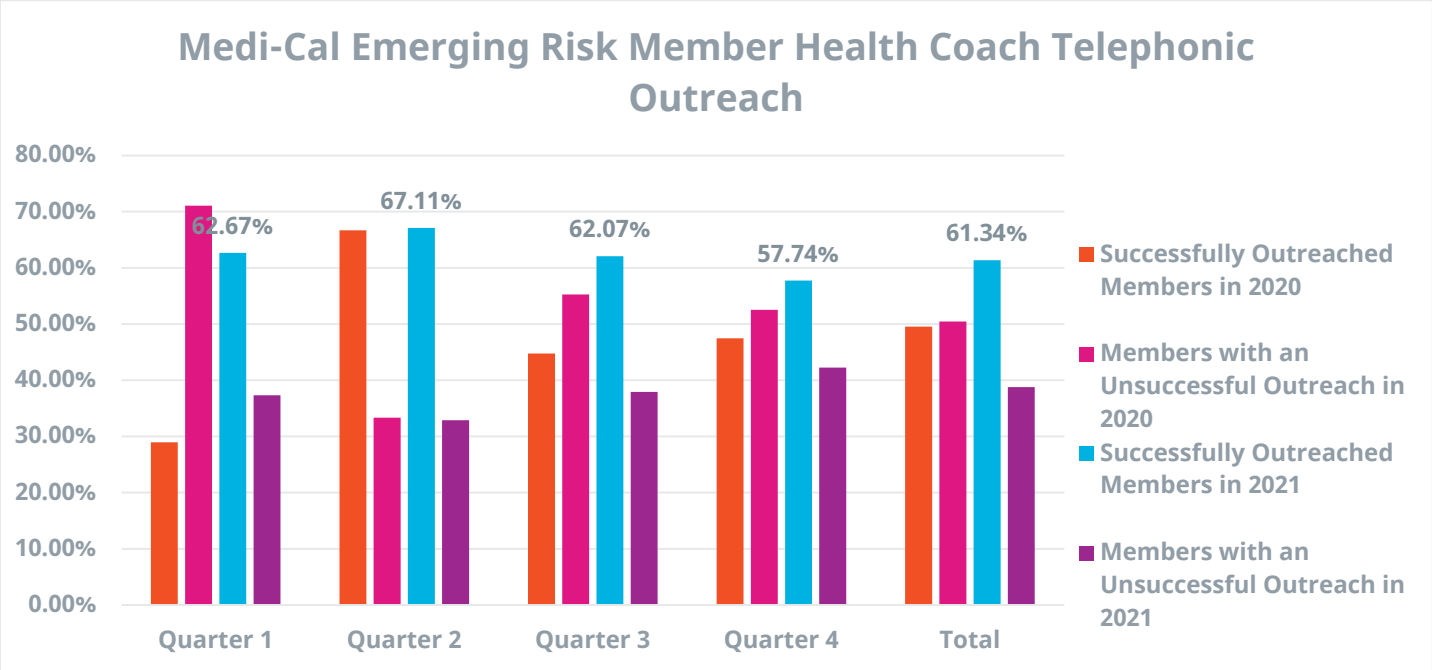
Interventions

- Health Coaching: To address an 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 as Emerging Risk members. Telephonic outreach is conducted by a health coach to identify solutions for Emerging Risk members to manage their HbA1c levels below 8.0%.
- Member Incentive: CalOptima Health offered a $25 gift card to eligible Medi-Cal members ages 18–75 who completed an HbA1c test between January to December 2021. The 2021 HbA1c test member health reward programs was promoted through the CalOptima Health website, member and provider newsletters, and social media including Facebook, Instagram and Twitter.

Findings

The rate of Emerging Risk members with a successful outreach by a Health Coach showed an increase in the trend of successful outreach attempts for each quarter. There was an increased number of members with a reduced HbA1c result in 2021.

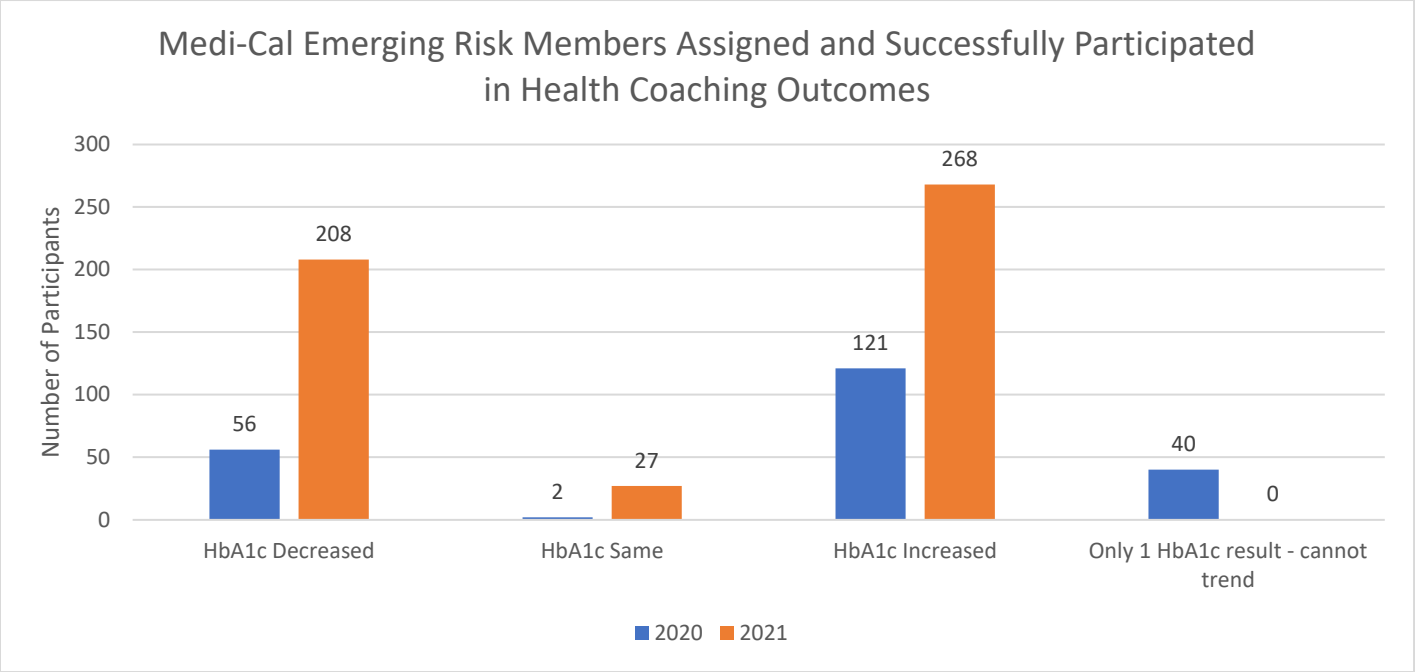
Figure 1: Medi-Cal Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (second column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (third column) and rate of assigned Emerging Risk members with an unsuccessful outreach (fourth column).

When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a reduced HbA1c result in 2021. Figure 2 illustrates in 2021 208 participants had HbA1c outcomes reduced while 268 participants had HbA1c outcomes increased.

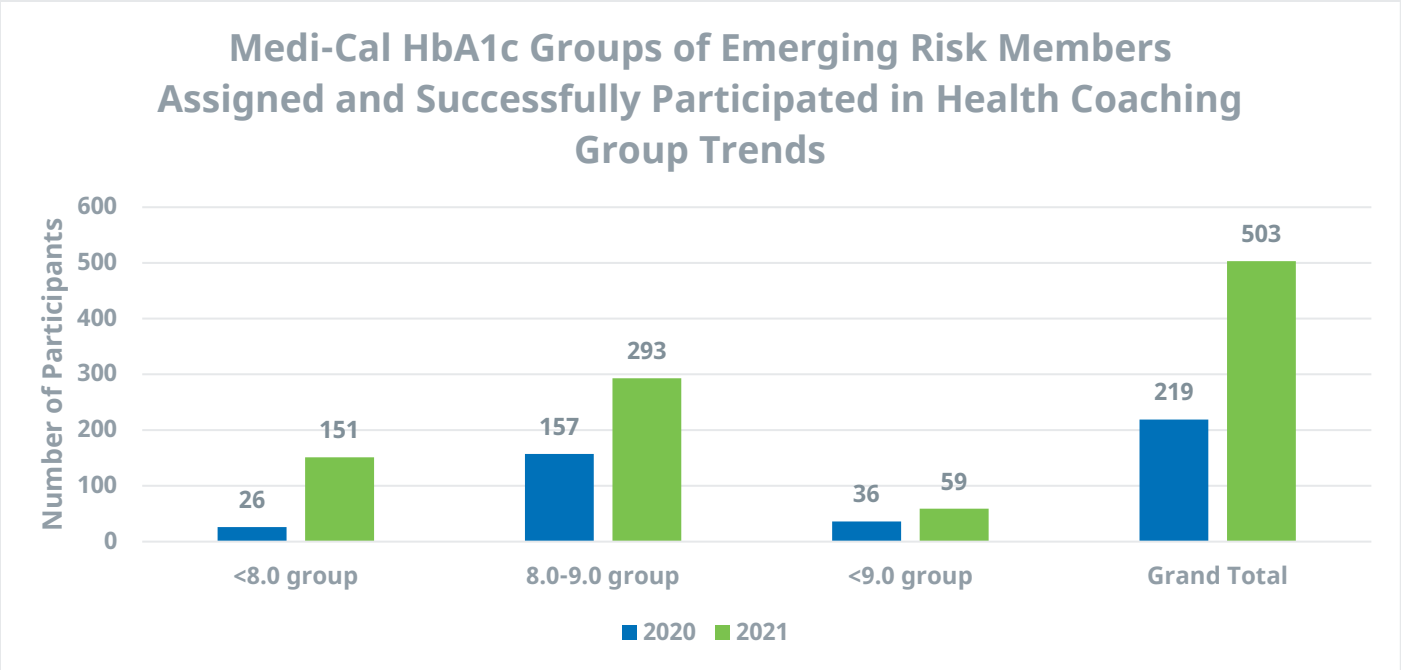
Figure 2: 2020 and 2021 Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' (HbA1c 8.0–9.0) HbA1c trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" (26/219 = 11.87%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (151/503 = 30.02%), the rate improved by 18.15%. Members who participated in telephonic outreach experienced a reduction in their HbA1c. Yet, in 2021 there were 293 members who fell into the Emerging Risk category, an increase when compared with 2020.

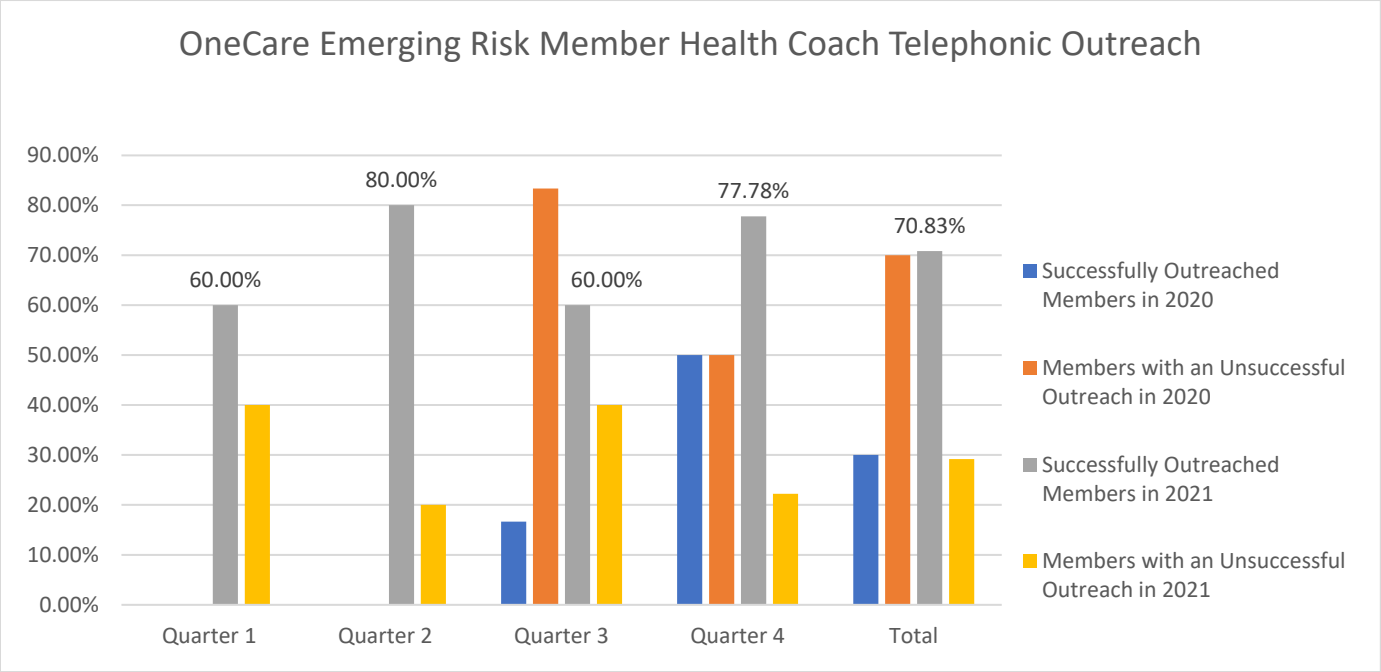
Figure 3: 2020 Medi-Cal HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

OneCare: When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, there was trend of increased successful outreach for each quarter. Figure 4 showcases the rate of outreach per assigned member in 2020 and 2021. There was a significant improvement in the rate of successful outreach to members in 2021.

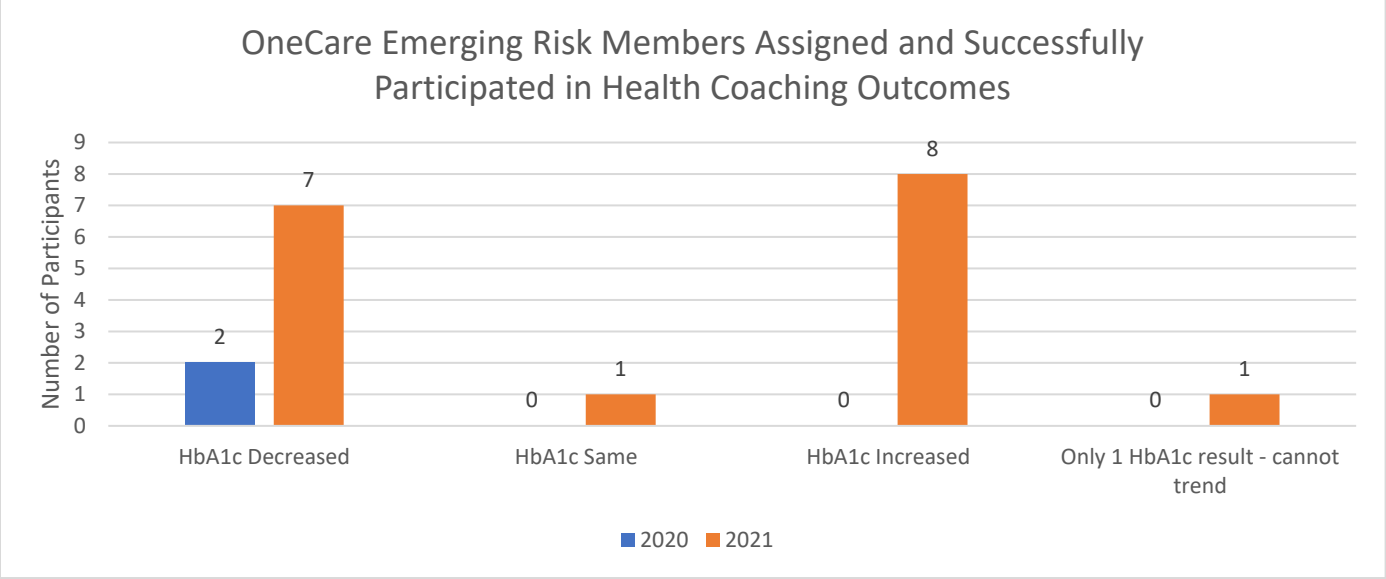
Figure 4: OneCare Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (second column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (third column) and rate of assigned Emerging Risk members with an unsuccessful outreach (fourth column).

When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Yet, there was a significant number of members whose HbA1c increased after participating in the program, as depicted in Figure 5.

Figure 5: OneCare Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes

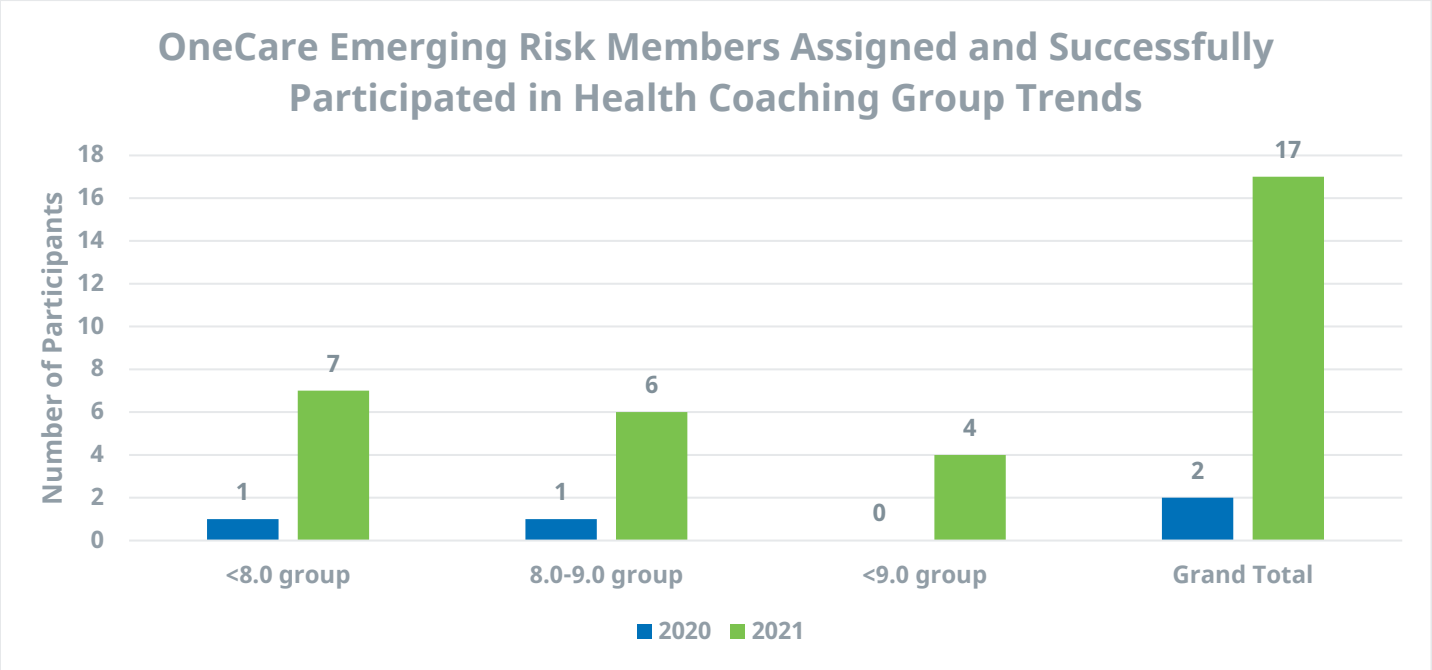


The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' (HbA1c 8.0–9.0) HbA1c trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were

categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in health coaching.

When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" (1/2 = 50.00%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (7/17 = 41.18%), the rate improved by 8.82% but there were more members who were assigned and fell into the HbA1c <8.0 group in 2021. Further details are in Figure 6.

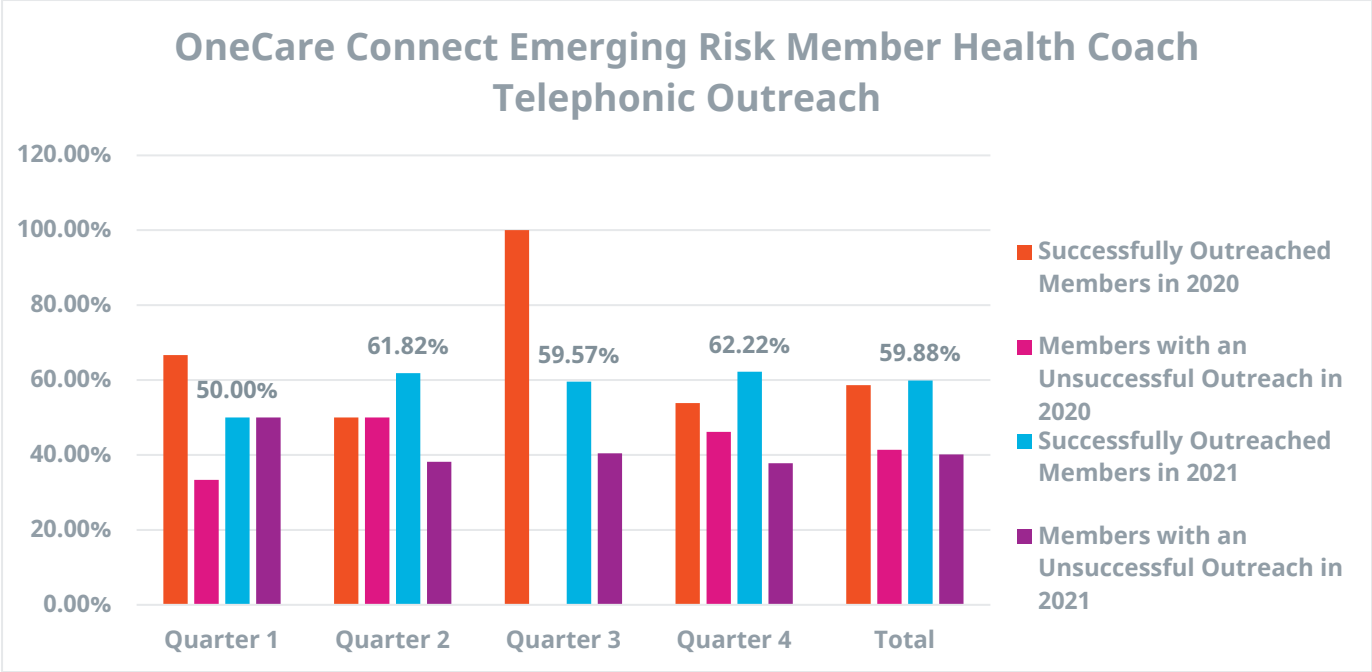
Figure 6: OneCare HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

OneCare Connect: When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, the trend varied for each quarter but overall, there was an improvement in 2021 by 1.26%.

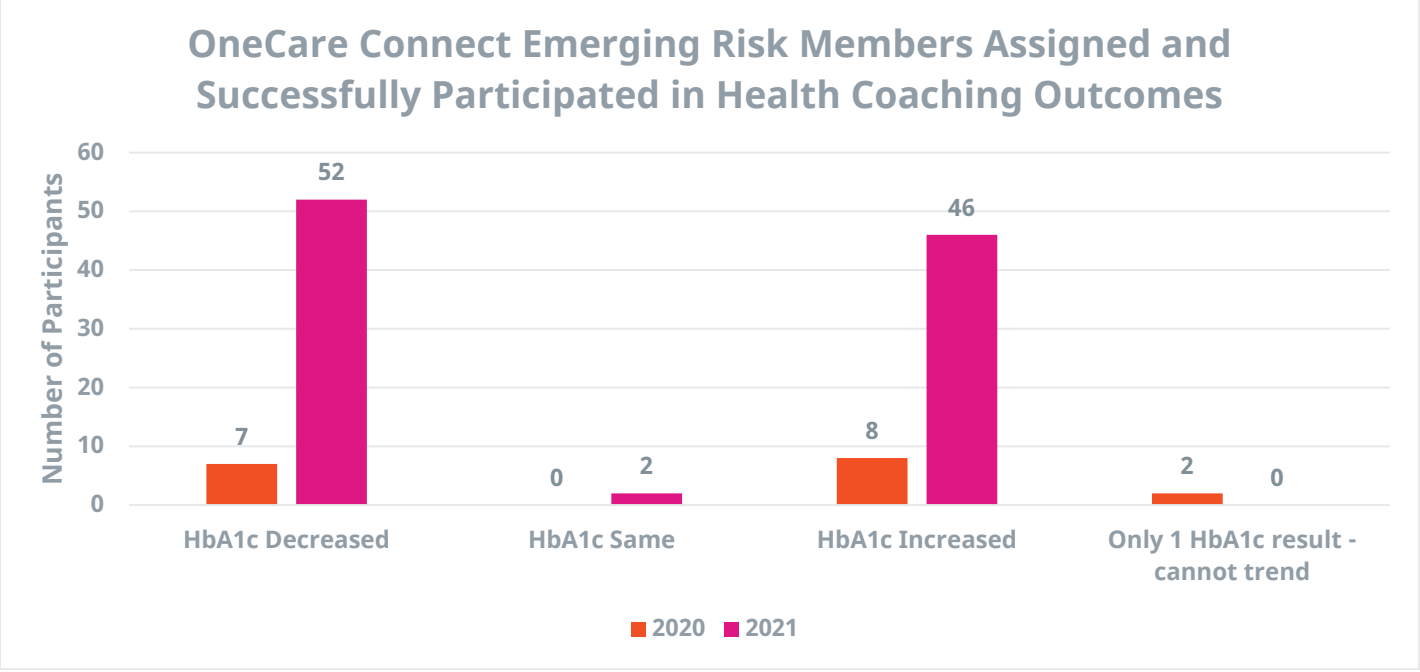
Figure 7: OneCare Connect Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (second column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (third column) and rate of assigned Emerging Risk members with an unsuccessful outreach (fourth column).

When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Figure 8 demonstrates that for the OneCare Connect population in 2021 this program helped reduce the HbA1c for most participants.

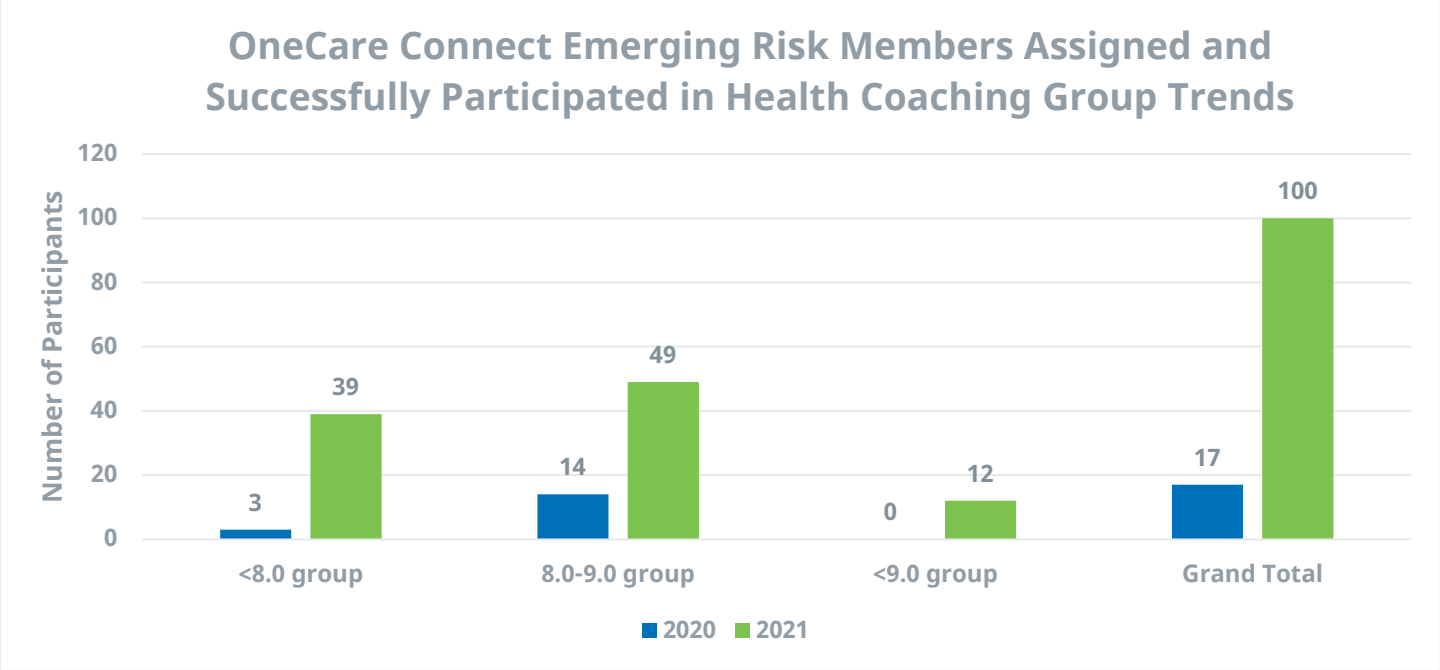
Figure 8: OneCare Connect Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' (HbA1c 8.0–9.0) HbA1c Trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in health coaching.

When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members who fell into "A1c <8.0 group" (3/17 = 17.65%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (39/100 = 39.00%), rate improved by 21.35 percentage points.

Figure 9: OneCare Connect HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in health coaching and which HbA1c groups they fell into at the end of 2020 and 2021.

Table 1: All LOBs HEDIS MY 2021 Rates by Race/Ethnicity CDC HbA1c Testing

Table 1	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Filipino	Asian/ Pacific Islander	Black	Korean	Asian Indian
Numerator	14,589	4,993	5,190	4,427	1,157	913	758	598	571	480
Denominator	17,274	6,182	5,719	5,223	1,372	1,022	865	753	667	548
Rate	84.46%	80.77%	90.75%	84.76%	84.33%	89.33%	87.63%	79.42%	85.61%	87.59%
KPI (QC 50th %)	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	88.66%	89.30%
Met/Not Met	Not Met	Not Met	**Met**	Not Met	Not Met	**Met**	Not Met	Not Met	Not Met	Not Met

HEDIS MY 2021 CDC HbA1c Testing submeasure results. Based on the top 10 highest race/ethnicity denominators. Two out of the 10 Race/Ethnicity met the 50th percentile for HbA1c Testing.

Member Incentive

Table 2 shows the HbA1c Test member incentive results and participation. When comparing the 2020 response rate to the 2021 response rate, it decreased by 2.98 percentage points.

Table 2: MY 2020 and MY 2021 Medi-Cal Member Incentive: HbA1c Test

	HEDIS Non-Compliant Members Eligible		Health Reward Forms Received		Response Rate	
Measure	*2020*	*2021*	*2020*	*2021*	*2020*	*2021*
HbA1c Test	20,532	18,368	863	225	4.20%	1.22%

HEDIS Rates

Table 3 below shows the 2021 and 2022 HbA1c Poor Control Prospective Rate Data for Medi-Cal. When comparing the rates from September 2022 and from September 2021, the HbA1c Poor Control measure showed a 5.72 percentage point increase.

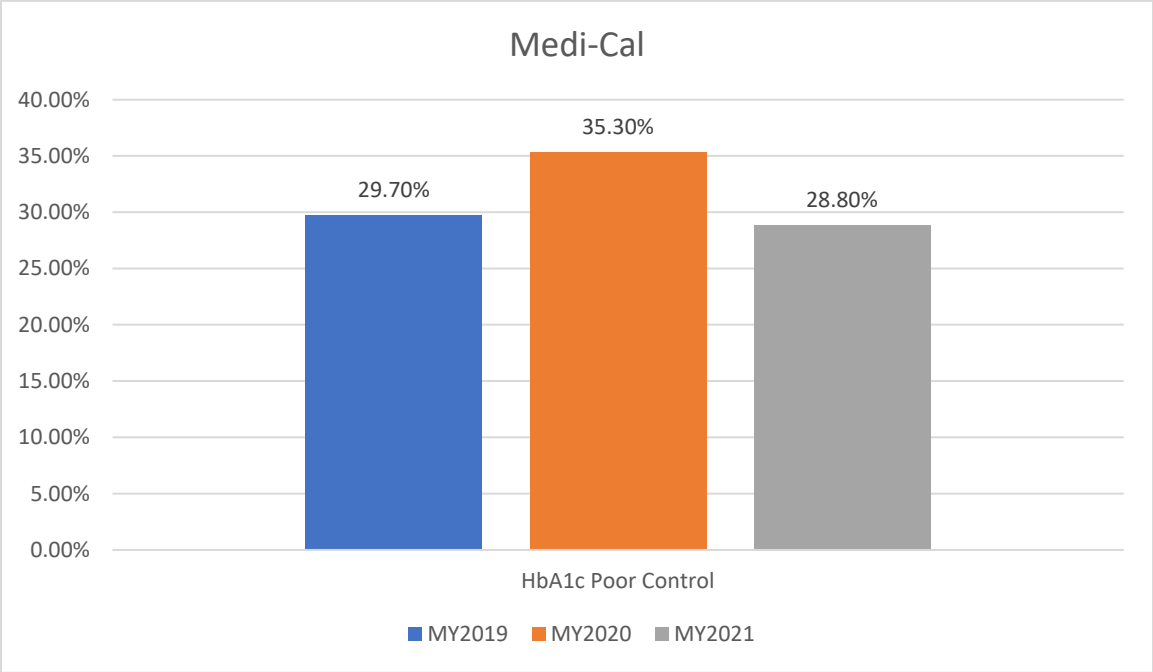
Table 3: HbA1c Poor Control

MY 2021 and MY 2022 Prospective Rates	**HbA1c Poor Control (This measure evaluates % of members with poor A1C control — lower rate is better)**	
Medi-Cal	***September 2021***	***September 2022***
Numerator	20,028	21,891
Denominator	34,991	38,738
Rate	57.24%	56.51%
KPI (QC 50th %)	37.47%	43.19%

Met/Not Met	Not Met	Not Met

The Figure 10 shows the Medi-Cal HEDIS MY 2019, MY 2020, MY 2021 results for HbA1c Poor Control. When comparing MY 2020 to MY 2021 HbA1c Poor Control rates, the rate decreased by 6.5 percentage points.

Figure 10: CDC HbA1c Poor Control HEDIS Results by Measurement Year: Medi-Cal

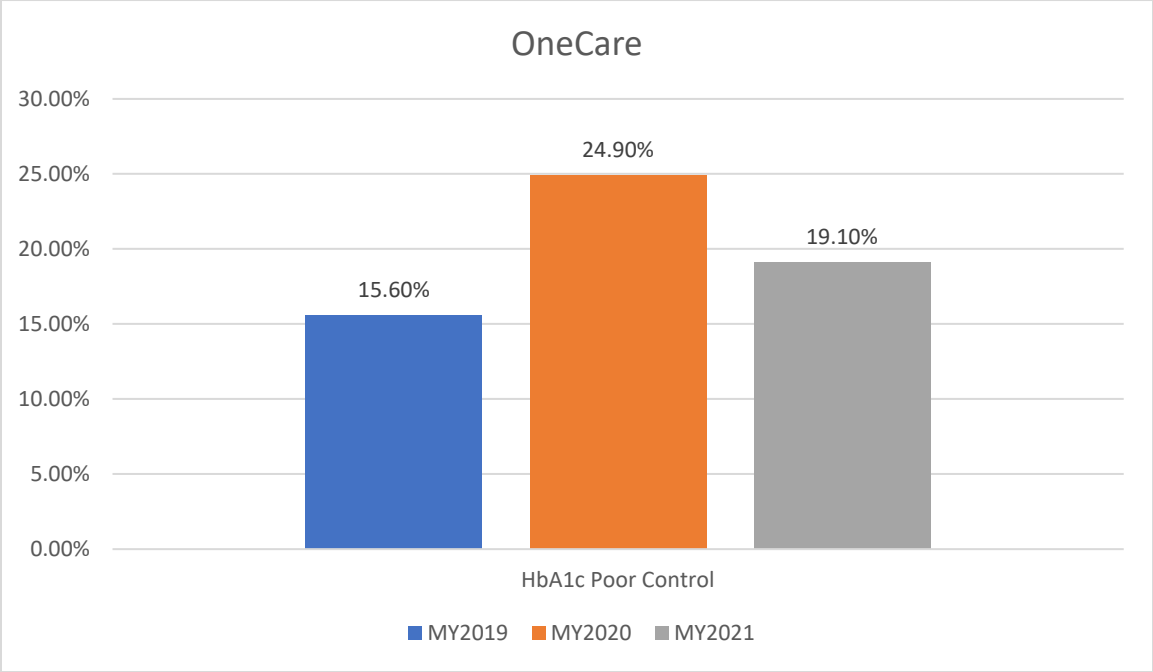


HEDIS Measure	**Percentile, Goal, and Reporting Requirements**				
HEDIS MY 2021 Medi-Cal	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*	*Goal*	*Reporting Requirements***
HbA1c Poor Control (>9.0%) (Lower is better)	48.18%	39.66%	34.06%	34.06%	++MPL, P4V
Goal Met/Not Met			Goal Met in MY 2021 90th Percentile		

*Met 90th percentile in MY 2021 for Medi-Cal. * MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value*

Figure 11 shows the OneCare HEDIS MY 2019, MY 2020, MY 2021 results for HbA1c Poor Control. When comparing MY 2020 to MY 2021 HbA1c Poor Control rates, the rate decreased by 5.8 percentage points.

Figure 11: CDC HbA1c Poor Control HEDIS Results by Measurement Year: OneCare

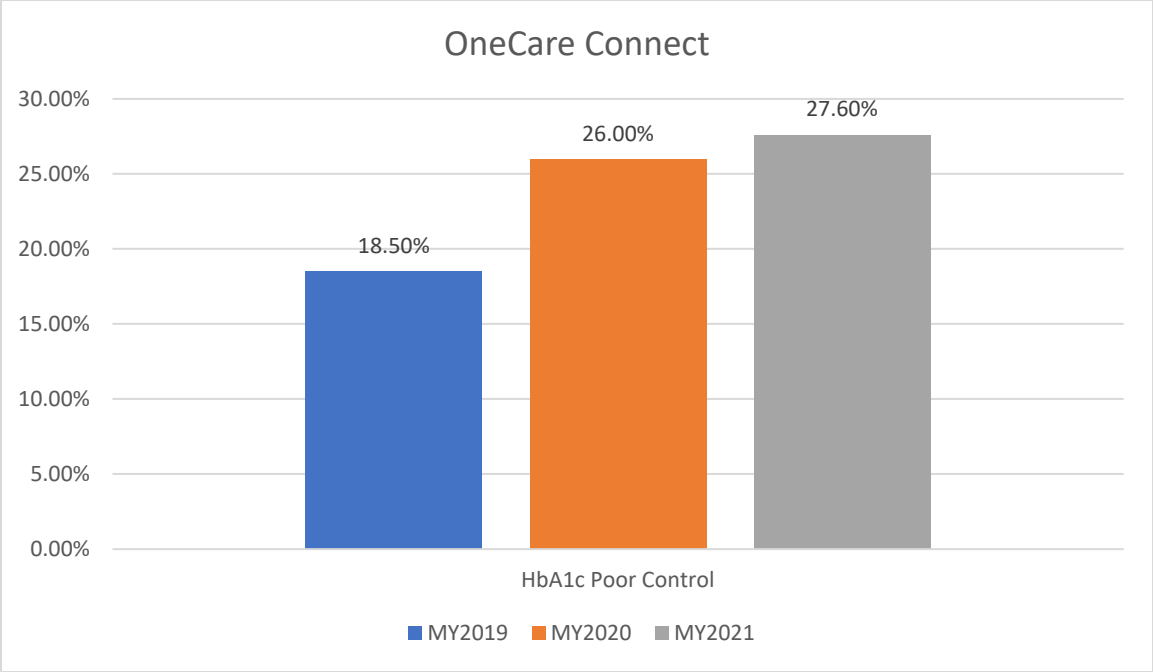


HEDIS Measure	Percentile, Goal, and Reporting Requirements				
HEDIS MY 2021 OneCare	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
HbA1c Poor Control (>9.0%) (Lower is better)	40%	28%	19%	19%	Star
Goal Met/ Not Met		Not Met in MY 2021, reached 66th percentile			

Met the 4-Star/66th percentile in MY 2021 for OneCare.
***Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference*

Figure 12 shows the OneCare Connect HEDIS MY 2019, MY 2020, MY 2021 results for HbA1c Poor Control. When comparing MY 2020 to MY 2021 HbA1c Poor Control rates, the rate increased by 1.60 percentage points.

Figure 12: CDC HbA1c Poor Control HEDIS Results by Measurement Year: OneCare Connect



HEDIS Measure	Percentile, Goal, and Reporting Requirements				
HEDIS MY 2021 OneCare Connect	*3-Star/33rd percentile*	*4-Star/66th percentile*	*5-Star/90th percentile*	*Goal*	*Reporting Requirements***
HbA1c Poor Control (>9.0%) (Lower is better)	40%	28%	19%	19%	Star, P4V
Goal Met/Not Met		Not Met in MY 2021, reached 66th percentile			

Met the 4-Star/66th percentile in MY 2021 for OneCare Connect.
***Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference.*

Analysis

a. Health Coaching

i. Medi-Cal

1. Goal: By 12/31/2021, the target goal of this intervention is to reduce the number of Medi-Cal Emerging Risk members by 5% for those who participated in the telephonic health coaching intervention.

2. As shown in the Findings section, out of the 503 members who successfully participated in health coaching, 151 members fell into the <8.0 group, which gives a rate of 30.02%. There were 293 members who remained in the 8.0–9.0 group (Emerging Risk) from the 503 members who successfully participated in health coaching, which gives a rate of 58.25%. The target goal for this intervention was to reduce the number of Medi-Cal Emerging Risk members 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 503. To achieve 5%, 26 emerging risk members were needed to be placed in the <8.0 group by the end of the year. The data shows that the Emerging Risk members at the end of 2021 were reduced by 151 Emerging Risk members who participated in the telephonic health coaching outreach being in the <8.0 Group (good control). This indicates that the goal of reducing the Emerging Risk members by 5% was met.

ii. OneCare

1. Goal: By 12/31/2021, the target goal of this intervention is to reduce the number of OneCare Emerging Risk members by 50% for those who participated in the telephonic health coaching intervention.

2. As shown in the Findings section, out of the 17 members who successfully participated in health coaching, 7 members fell into the <8.0 group, which gives a rate of 41.18%. There were 6 members who remained in the 8.0–9.0 group (Emerging Risk) from the 17 members who successfully participated in health coaching, which gives a rate of 35.29%. The target goal for this intervention was to reduce the number of OneCare Emerging Risk members 50% (from baseline of 5) by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 17. To achieve a 50% reduction of that figure, we needed at least 9 Emerging Risk members to be placed in the <8.0 group by the end of the year. The data shows that the 7 Emerging Risk members at the end of 2021 who participated in the telephonic health coaching outreach were placed in the <8.0 Group (good control). This indicates that we did not meet the goal of reducing the Emerging Risk members by 50%.

iii. OneCare Connect

1. Goal: By 12/31/2021, the target goal of this intervention is to reduce the number of OneCare Connect emerging risk members by 5% for those who participated in the telephonic health coaching intervention.

2. As shown in the Findings section, out of the 100 members who successfully participated in health coaching, 39 members fell into the <8.0 group, which gives a rate of 39%. There were 49 members who remained in the 8.0–9.0 group (Emerging Risk) from the 100 members who successfully participated in health coaching, which gives a rate of 49%. The target goal for this intervention was to reduce the number of OneCare Connect Emerging Risk members by 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 100. To achieve a 5% reduction of that figure, at least 5 Emerging Risk members needed to be placed in the <8.0 group by the end of the year. The data shows that 39 Emerging Risk members at the end of 2021 who participated in the telephonic health coaching outreach were placed in the <8.0 Group (good control). This indicates that we met the goal of reducing the Emerging Risk members by 5%.

b. Member Incentive

   i. In MY 2020 of the 20,532 who were eligible for the HbA1c Test member health reward, 863 submitted HbA1c Test health reward forms, yielding a 4.20% response rate.

   ii. In MY 2021 of the 20,532 who were eligible for the HbA1c Test member health reward, 863 submitted HbA1c Test health reward forms, yielding a 4.20% response rate.

Barriers

c. Barriers encountered during the Health Coach telephonic outreach include:

   i. There was limited capacity for the health educators to conduct outbound calls due to their competing volume of daily tasks.

   ii. The Health Coaches had difficulty with scheduling appointments. Appointments are scheduled far out, especially for endocrinologists due to their limited office hours.

   iii. With the COVID-19 pandemic, telehealth appointments were difficult for some members to perform due to the lack of access to a smartphone or not understanding the instructions on how to connect to a video call.

   iv. Members rely on natural remedies to reduce their blood sugar.

   v. Members face challenges with access to broadband/internet based on their economic status or place of residence.

   vi. Members may require transportation to attend appointments and may not be aware of their transportation benefits.

d. Barriers encountered for member incentive include:

   i. Members may continue to be reluctant to go to their provider's office due to the COVID-19 pandemic.

ii. Incomplete Forms: HbA1c test reward forms regularly came back with the HbA1c value field empty, or members completed the form themselves with a blood sugar value reading rather than a HbA1c test value.

iii. Our current process may be a barrier for members to complete forms and acquire signatures.

iv. Many members completed and submitted the forms without having the test performed. Some of the forms submitted contained old dates of service, which disqualified them for receiving the member incentive.

v. Members gave the form to their provider assuming the provider will fax the completed form to CalOptima Health. However, CalOptima Health often did not receive those submissions.

vi. Members submit the form but with a date of service outside the incentive timeframe.

vii. The HbA1c testing is usually performed quarterly or as directed by a provider. This may have l led to member lab visit fatigue due to the frequent lab visits for testing.

viii. In 2021, CalOptima Health did not conduct member mailers for HbA1c due to budget limitations with mailing health reward forms to eligible members.

ix. It was observed that the Electronic Health Record (EHR) often lacked data or was missing lab data. This impacted the measure because we were unable to distinguish compliant from noncompliant members.

x. Members who did not qualify for the member incentive rewards, including OneCare, OneCare Connect and Kaiser members, attempted to participate in the program.

xi. Members who were not diagnosed as diabetic attempted to participate in member incentive rewards.

Opportunities for Improvement

e. Health Coaching

i. Instruct Health Coaches to assist members with scheduling appointments whenever possible. Teach members how to navigate the health system and telehealth appointments. Encourage members to communicate needs and challenges timely to their provider.

ii. During outbound calls, conduct a short questionnaire screening for social determinants of health and connect members with other resources to assist with specific needs.

iii. Update telephonic scripting to mention diabetic resources and telehealth options.

iv. Seek ways to improve data needs and streamline how members are assigned to Health Coaches moving from manual to an automated method.

v. Conduct a multilayered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine if social determinants of health that may be creating barriers for CalOptima Health members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.

f. Member Incentive

i. Need to improve and place a greater emphasis on compliance with diabetic HbA1c testing and eye exams. Along with all other incentives, there should be a more concerted effort for greater promotion and marketing of the diabetes member rewards through the health networks, CCN providers and the community.

ii. Reiterate the importance of fully completing the member health reward forms and following up with the provider, through provider fax updates or phone calls to the provider offices.

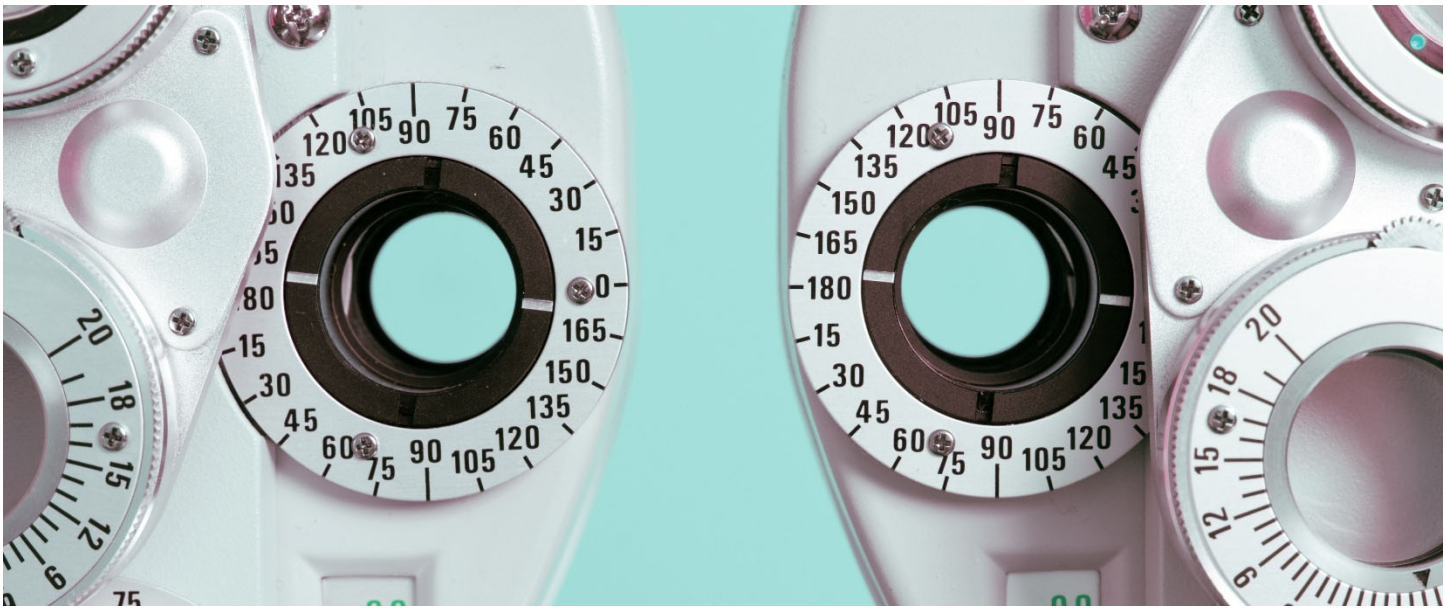
iii. Consider adding mail distribution costs to the budget for the mailing of health reward forms to eligible members to increase awareness.

iv. Leverage social media as a platform to encourage HbA1c testing.

v. Allocate resources to improve data collection and access to an EHR by improving lab data completion.

vi. Collaborate closely with community partners when implementing health rewards to raise member awareness.

vii. Conduct current member data analysis considering age groups, ethnicity and ZIP codes for non-compliance trends and to strategize for better outcomes.



Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): Eye Exam

Comprehensive Diabetes Care (CDC): Eye Exam is defined as members ages 18–75 with diabetes (type 1 and type 2) who had a recent retinal eye exam during the measurement year. Screening or monitoring for diabetic retinal disease as identified by administrative data.

CDC: Eye Exam

Interventions

Member Incentive: CalOptima Health offered a $25 gift card to eligible Medi-Cal members ages 18–75 who completed a diabetes retinal eye exam test between January to December 2021. The 2021 Eye Exam member health reward was promoted through the CalOptima Health website, member and provider newsletters, and social media, including Facebook, Instagram and Twitter.

Findings

Member Incentive: Table 1 below shows the Eye Exam member incentive results. When comparing the 2020 response rate to the 2021 response rate, it decreased by 4.21 percentage points.

Table 1: Member Incentive

	MY 2020 – MY 2021 Medi-Cal Member Incentive: Eye Exam					
	HEDIS Non-Compliant Members Eligible		*Health Reward Forms Received*		*Response Rate*	
Measure	*2020*	*2021*	*2020*	*2021*	*2020*	*2021*
Eye Exam	15,196	22,884	736	144	4.84%	0.63%

Table 2 shows the 2021 and 2022 Eye Exam Prospective Rate Data for Medi-Cal. When comparing the rates from September 2022 and from September 2021, the Eye Exam measure showed a 7.28 percentage point decrease.

Table 2: Eye Exam

MY 2021 and Prospective Rates for MY 2022	Eye Exam	
Medi-Cal	***September 2021***	***September 2022***
Numerator	16,044	17,524
Denominator	34,991	38,738
Rate	45.85%	45.24%
KPI (QC 50th %)	58.64%	51.36%
Met/Not Met	Not Met	Not Met

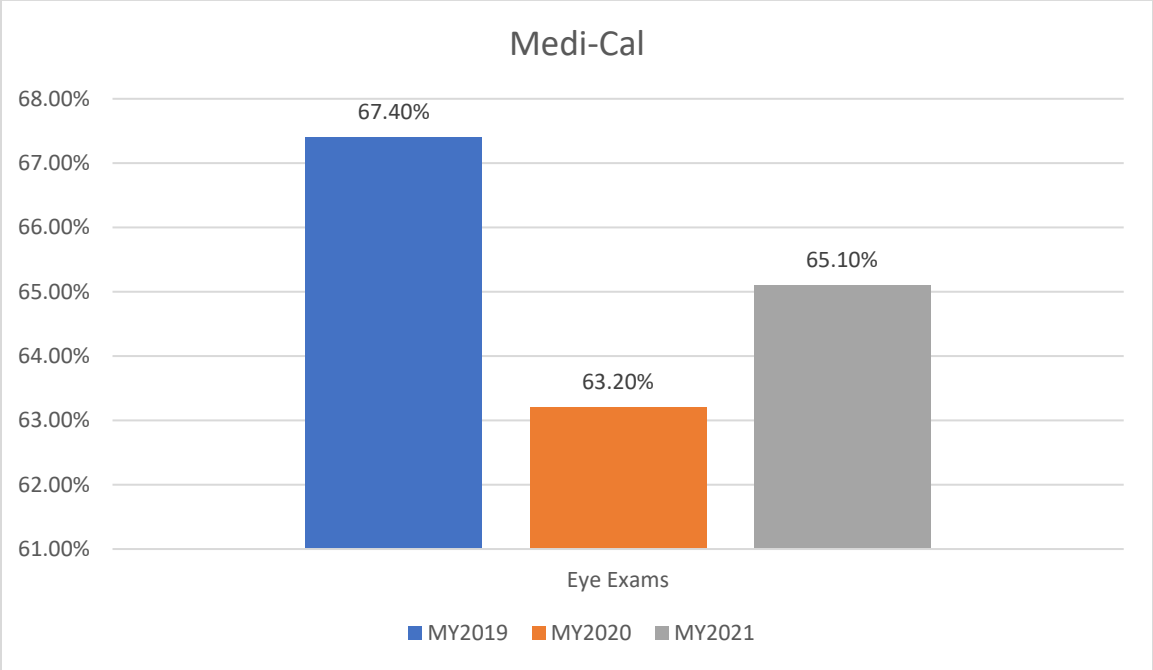
Table 3: All LOBs HEDIS MY 2021 Rates by Race/Ethnicity CDC Eye Exam

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Filipino	Asian/Pacific Islander	Korean	Black	Asian Indian
Numerator	8,614	2,484	3,295	2,442	580	542	423	384	327	285
Denominator	15,715	5,358	5,294	4,591	1,149	890	714	654	653	499
Rate	54.81%	46.36%	62.24%	53.19%	50.48%	60.90%	59.24%	58.72%	50.08%	57.11%
KPI (QC 50th %)	63.35%	63.35%	63.35%	63.35%	63.35%	63.35%	63.35%	63.35%	62.15%	63.35%
Met/Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met

HEDIS MY 2021 CDC Eye Exam submeasure results. Based on the top 10 highest race/ethnicity denominators. Out of the 10 Race/Ethnicity listed above, none met the 50th percentile for Eye Exam.

Figure 1 below shows the Medi-Cal HEDIS MY 2019, MY 2020, MY 2021 results for Eye Exam. When comparing MY 2020 to MY 2021 Eye Exam rates, the rate increased by 1.9 percentage points.

Figure 1: CDC Eye Exam Results by Measurement Year, Medi-Cal

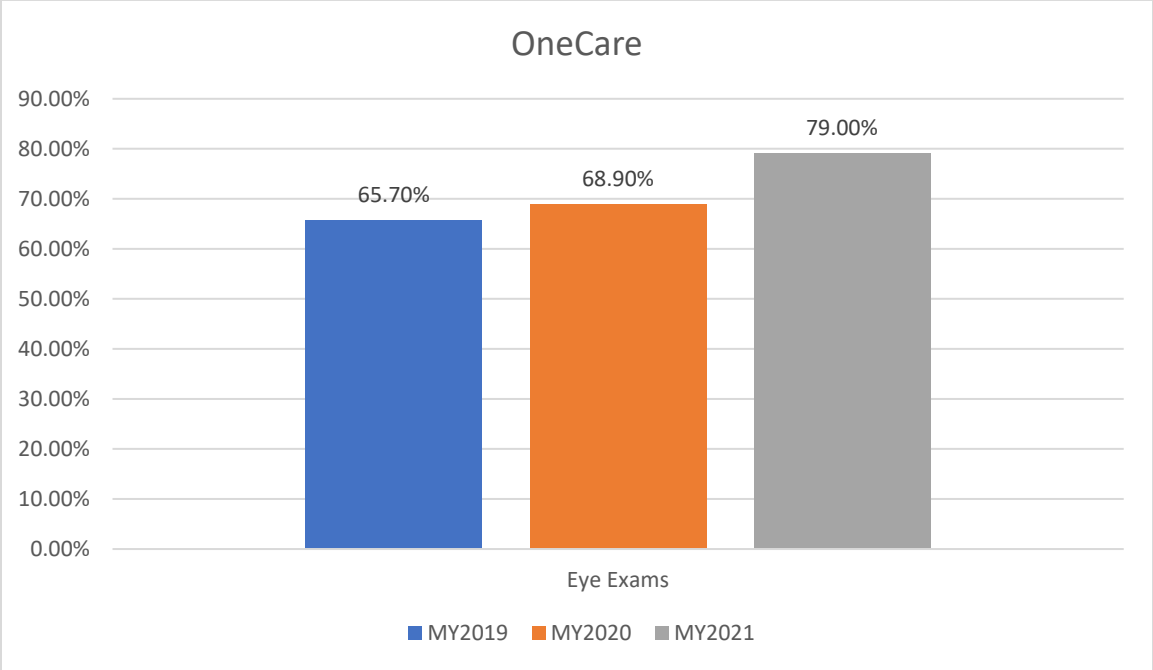


HEDIS Measure	Percentile, Goal and Reporting Requirements				
HEDIS MY 2021 Medi-Cal	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*	*Goal*	*Reporting Requirements***
Eye Exam	54.26%	63.26%	71.23%	71.23%	HPR
Goal Met/Not Met		Goal not met in MY 2021, met 66th Percentile			

*Met 66th percentile in MY 2021 for Medi-Cal. ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value*

Figure 2 shows the OneCare HEDIS MY 2019, MY 2020, MY 2021 results for Eye Exam. When comparing MY 2020 to MY 2021 Eye Exam rates, the rate increased by 10.1 percentage points.

Figure 2: CDC Eye Exam Results by Measurement Year, OneCare

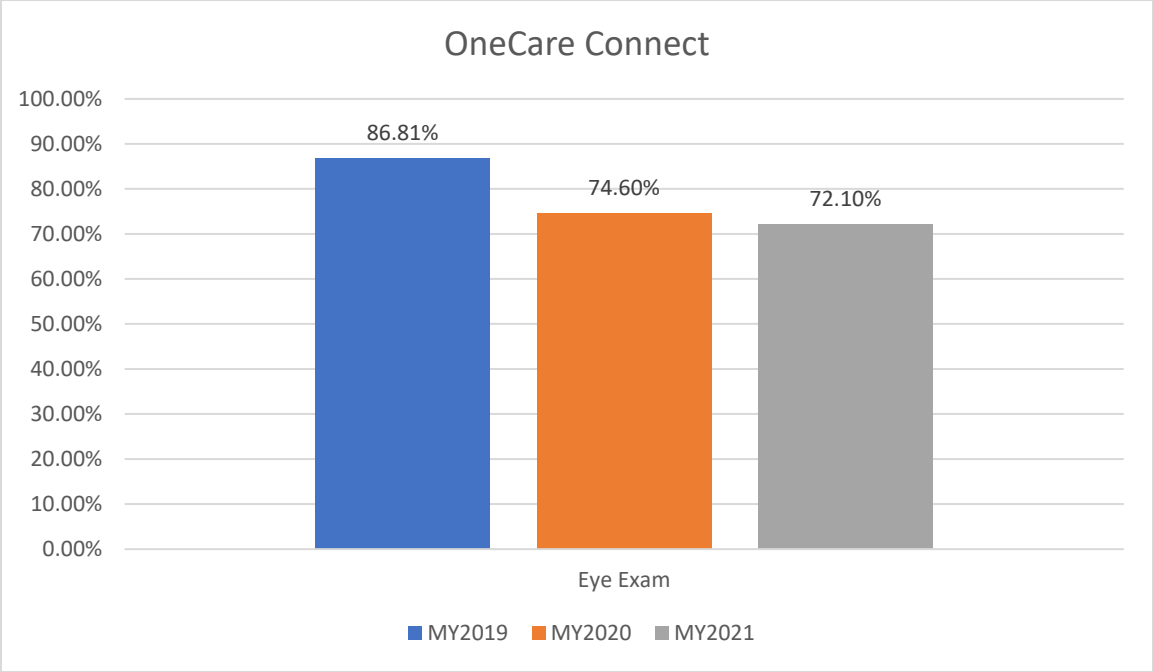


HEDIS Measure	Percentile, Goal and Reporting Requirements				
HEDIS MY 2021 OneCare	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
Eye Exam	62%	71%	79%	**71%**	Star
Goal Met/Not Met			Goal met in MY 2021, met 90th Percentile		

*Met 5-Star/90th percentile in MY 2021 for OneCare. **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference*

Figure 3 shows the OneCare Connect HEDIS MY 2019, MY 2020, MY 2021 results for Eye Exam. When comparing MY 2020 to MY 2021 Eye Exam rates, the rate decreased by 2.50 percentage points.

Figure 3: CDC Eye Exam Results by Measurement Year, OneCare Connect



HEDIS Measure	Percentile, Goal and Reporting Requirements				
HEDIS MY 2021 OneCare Connect	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
Eye Exam	62%	71%	79%	79%	Star
Goal Met/Not Met		Goal not met in MY 2021, met 66th Percentile			

*Met 4-Star/66th percentile in MY 2021 for OneCare Connect. **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference*

Analysis

Member Incentive: In MY 2020 of the 15,196 who were eligible for the Eye Exam member health reward, 736 submitted Eye Exam health reward forms, yielding a 4.84% response rate. In MY 2021, the response rate was 0.63% yielding 144 of the 22,884 who were eligible.

Barriers

a. Barriers encountered for the member incentives include:

   i. Members may still be reluctant to go to their provider's office due to the COVID-19 pandemic.

   ii. The Eye Exam reward forms were often returned, incomplete, contained incorrect information, were not signed by the provider or were illegible.

iii. Many members completed and submitted the forms without having the test performed or submitted the forms with old dates of service, which disqualified them for receiving the member incentive.

iv. Members gave the form to their provider assuming the provider will fax the completed form to CalOptima Health. However, CalOptima Health often did not receive those submissions.

v. In 2021, CalOptima Health did not conduct member mailers for Eye Exam due to budgetary limitations with mailing health reward forms to eligible members.

vi. It was observed that the Electronic Health Record (EHR) often lacked data or was missing lab data causing us to be unable to distinguish compliant from noncompliant members.

vii. Members who did not qualify for the member incentive rewards, including OneCare and OneCare Connect and Kaiser members, attempted to participate in the program.

viii. Members who were not diagnosed as diabetic attempted to participate in member incentive rewards

Opportunities for Improvement

b. Member Incentive

i. CalOptima Health will consider having the diabetes reward available to all CalOptima Health members with diabetes to encourage yearly eye exams.

ii. CalOptima Health needs to improve and place a greater emphasis on compliance with Diabetes HbA1c Testing and Eye Exam and will make a greater effort for promotion and marketing of the diabetes member rewards through the health networks, CCN providers and the community.

iii. CalOptima Health will reiterate the importance of completing health reward forms in full and following through with the submission of forms.

iv. CalOptima Health will consider budgeting for mailing health reward forms to eligible members to increase awareness.

v. CalOptima Health will leverage social media as a platform to encourage obtaining Eye Exams.

vi. CalOptima Health will allocate resources to EHR to improve data collection and access, which will reduce issues related to missing data.

c. Improve collaborations with key stakeholders

i. CalOptima Health will collaborate closely with community partners when implementing health rewards to raise awareness of the program for members.

ii. CalOptima Health will conduct current member data analysis considering age groups, ethnicity and ZIP codes for noncompliance trends and to strategize for better outcomes.

iii. In 2022, CalOptima Health implemented a co-branding reminder letter with VSP Vision Plan to improve the Diabetic Annual Eye Exam completion rate.

Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care

Prenatal and Postpartum Care (PPC) is a hybrid measure and Managed Care Accountability Set (MCAS) measure with two components: the Timeliness of Prenatal Care, and Postpartum Care. PPC measures the percentage of deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year in which the members: 1) received a prenatal care visit in the first trimester, and 2) obtained a postpartum care visit on or between 7 and 84 days (1–12 weeks) after delivery. PPC is held to the minimum performance level (MPL) as determined by the NCQA National Quality Compass Benchmarks.

Interventions

a. Bright Steps Program (BSP) for Perinatal and Postpartum Members: BSP is a CalOptima Health program that offers education, educational materials, resources and support for mom and baby via phone calls throughout each trimester and the postpartum timeframe. BSP was launched in September 2018. Since then, the program has evolved to include a post BSP well-child follow up call initiative to support the member's continuum of care.

    i. Members engaged in Comprehensive Perinatal Services Program (CPSP) through a CPSP certified provider. During the 2021 calendar year, the BSP conducted outreach to 4,128 members for a total of 1,148 completed assessments.

    ii. BSP offers participants a member mailing with topics related to prenatal and postpartum care. During the 2021 calendar year, 1,988 members received a BSP packet mailing.

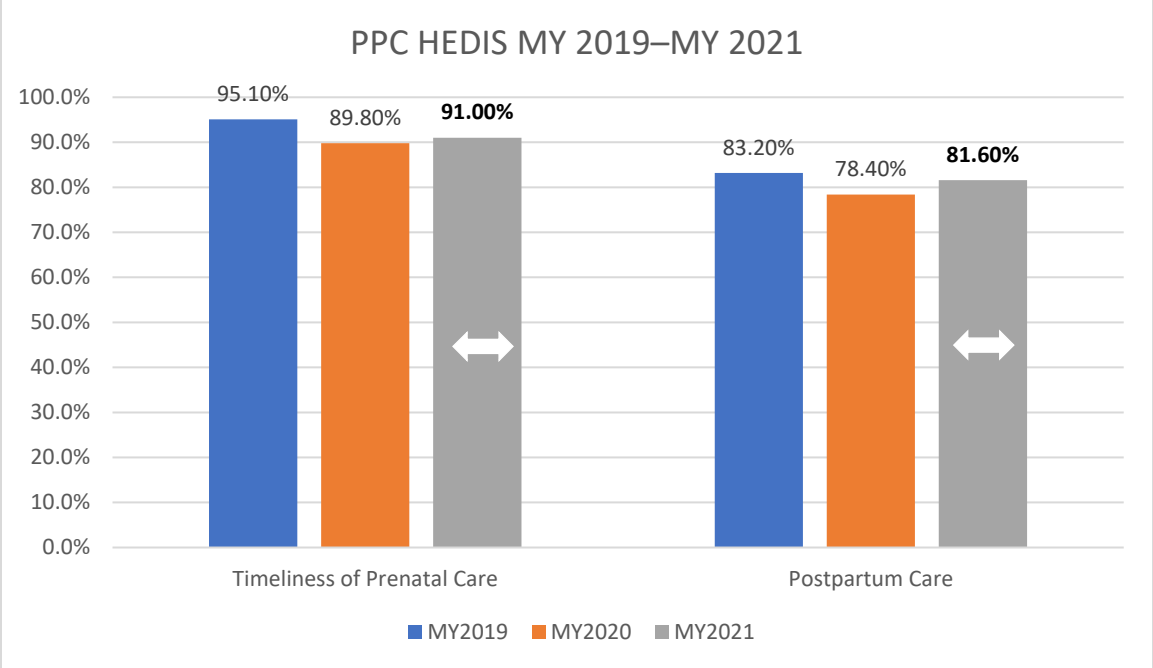
b. Medi-Cal members received a $50 Postpartum Checkup Health Reward for completing a postpartum checkup. The health reward was promoted to members via CalOptima Health website, Medi-Cal member newsletter and BSP. During the 2021 calendar year, 400 members were approved for the health reward.

c. Additional intervention included Pay 4 Value (P4V) metrics for prenatal and postpartum care, social media campaign, CalOptima Health website promotion, Healthcare Chat Video, member newsletter, and provider newsletter and fax.

Findings

Prenatal and Postpartum Care achieved the HEDIS MPL rate, 91.00% and 81.60% respectively. See Figure 1. Statistically there was no difference from MY 2020 to MY 2021 rates. Postpartum care rates are lower than prenatal care rates, thus interventions should continue to drive postpartum care efforts.

Figure 1: PPC Trending HEDIS Rates MY 2019–MY 2021 Results: Medi-Cal Timeliness of Prenatal Care and Postpartum Care



Trend analysis of final HEDIS rates for Prenatal Care and Postpartum Care (PPC). ***Bold*** *percentile indicates that the organization's goal was met. White arrow indicates that there was no statistical significance in rates when compared to the year prior.*

d. In addition to meeting the MPL, Prenatal and Postpartum Care met the organization's percentile goal, 90.75% and 79.56% respectively. See Table 1.

Table 1: Prenatal and Postpartum Care Measure Medi-Cal Percentiles and Organization Goal

HEDIS Measure	Percentile, Goal Reporting Requirements						
HEDIS MY 2021	*QC 33rd Percentile*	*QC 66th Percentile*	*QC 90th Percentile*	*Final HEDIS Rate*	*Goal*	*Reporting Requirements***	*Metrics Met*
Prenatal Care	81.51%	88.32%	92.21%	91.00%	90.75%	HPR, MPL, P4V	Organization goal, MPL
Postpartum Care	73.72%	78.35%	83.70%	81.60%	79.56%	HPR, MPL, P4V	Organization goal, MPL

***HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

Table 2 examines prenatal and postpartum care rates by ethnicity. When analyzing timely prenatal care by ethnicity, Korean members have the highest rates of timely prenatal care (90.41%) compared with other groups. Korean members along with other groups (e.g., Filipino, Chinese, Asian or Pacific Islander) represent a small portion of the total denominator. The Hispanic group represents the highest volume with more than half of the HEDIS denominator, but overall compliance is 82.60%. When analyzing timely postpartum care by ethnicity, Vietnamese members have the highest rates of timely postpartum care (85.25%) compared with other groups but represent a small volume. In terms of volume, the Hispanic group is the largest, but their rate of timely postpartum care is 70.70%. See Table 2.

Table 2: MY 2021 Prenatal and Postpartum Care HEDIS Results by Ethnicity

Hybrid	Ethnicity									
HEDIS MY 2021	*Hispanic*	*Other*	*White*	*Vietnamese*	*No response*	*Black*	*Filipino*	*Korean*	*Asian or Pacific Islander*	*Chinese*
Denominator	3,942	1,335	953	488	326	136	77	73	47	35
Prenatal Care Numerator	3,256	1,088	734	375	264	109	58	66	35	28
Prenatal Care Rate	82.60%	81.50%	77.02%	76.84%	80.98%	80.15%	75.32%	90.41%	74.47%	80.00%
Postpartum Care Numerator	2,787	948	608	416	222	93	53	58	39	27
Postpartum Care Rate	70.70%	71.01%	63.80%	85.25%	68.10%	68.38%	68.83%	79.45%	82.98%	77.14%

Table 2 displays top 10 ethnicities with the highest denominator based on total HEDIS population and the completion rates of timely prenatal and postpartum care. Prenatal and Postpartum are hybrid measures. The total rate does not indicate the final HEDIS rate. Note: Includes Kaiser members.

Table 3 examines postpartum care rates by member written language. The highest postpartum care completion rate is among Vietnamese members (84.87%), although this group represents less than 5% of the total denominator (n=7,497). The lowest rate is among English speaking members (69.37%), but the group represents the largest percentage of the total denominator (74.60%). MY 2021 findings are consistent with MY 2020 findings.

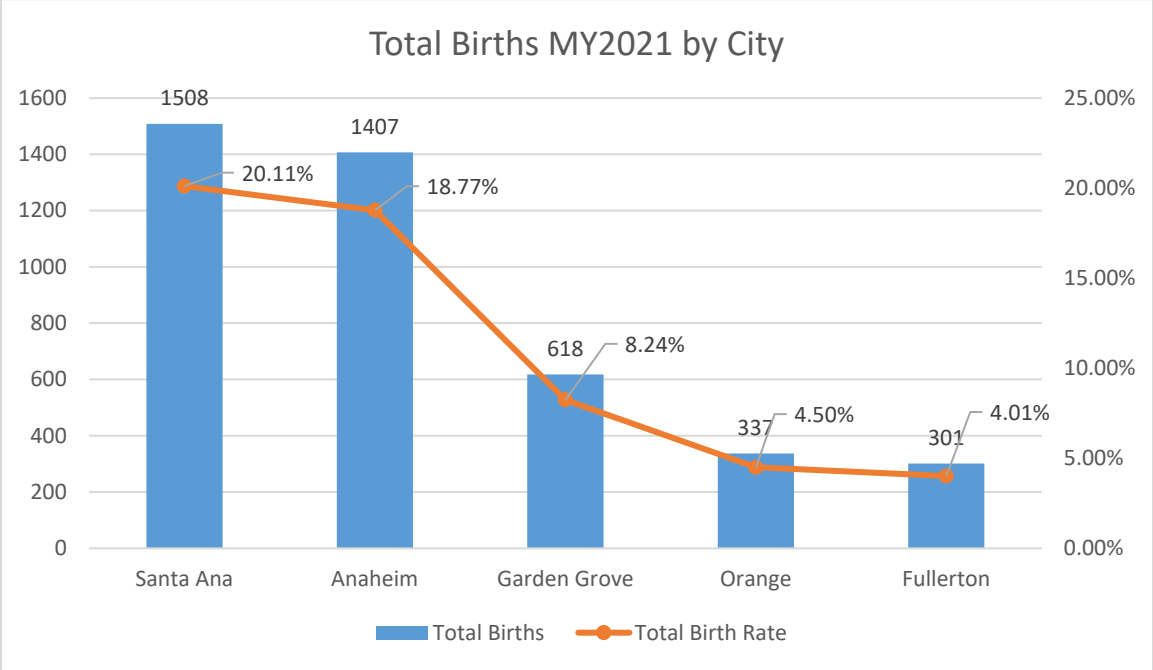
Table 3: MY 2021 Postpartum Care HEDIS Results by Threshold Language

Hybrid	**Threshold Language**					
HEDIS MY 2021	*English*	*Spanish*	*Vietnamese*	*Arabic*	*Korean*	*Farsi*
Numerator (completed postpartum care)	3,880	1,044	286	37	23	20
Denominator	5,593	1,441	337	52	31	28
Postpartum Care Completion Rate	69.37%	72.44%	84.87%	71.15%	74.19%	71.43%
% of Total Denominator	74.60%	19.22%	4.50%	0.69%	0.41%	0.37%

Table 3 displays the top threshold languages for members. The numerator indicates the members with that preferred language who received postpartum care. Note: Based on member written language preference; includes Kaiser members.

Figure 2 examines total births by city. Santa Ana, Anaheim and Garden Grove have the highest birth rate in Orange County at 20.11%, 18.77% and 8.24% respectively. This finding is consistent with the MY 2020 findings; no statistical significance and aligns with the total membership volume by city. Furthermore, these cities have the highest rate of members who do not receive timely prenatal and postpartum care, which is also consistent with MY 2020 findings.

Figure 2: Total Births in MY 2021 by City



Top 5 cities that represent the highest births in MY 2021.

a. Out of the total births (n=7,497) in MY 2021, 6,072 (81.00%) members completed prenatal care in a timely manner, 5,302 (70.72%) completed postpartum care, and 4,596 (61.03%) completed both prenatal and postpartum care, which represents a 1.23 percentage point increase from the MY 2020 rate (59.80%).

b. When analyzing members who received both timely prenatal and postpartum care, members 19 years of age and under have lower timely care rates (55.43%) than other age groups. When analyzing prenatal and postpartum care independently, differences can be seen across different age groups. Members who are 19 years of age and under have the lowest timely prenatal care rates (77.12%) compared with other age groups. See Table 4. Members ages 35–39 (69.02%) had lower completion rates of postpartum care, followed by those 19 years of age and younger (69.80%).

Table 4: Prenatal and Postpartum Care HEDIS Measure Rate by Age

Hybrid	Age Group						
HEDIS MY 2021	*≤19*	*≤20–24*	*≤25–29*	*≤30–34*	*≤35–39*	*≤40–44*	*≥45*
MY 2021 Denominator	341	1,720	2,333	1,796	1,007	281	19
Prenatal Care Numerator	263	1,410	1,911	1,448	805	220	15
Prenatal Care Rate	77.12%	81.98%	81.91%	80.62%	79.94%	78.29%	78.94%
Postpartum Care Numerator	238	1,211	1,640	1,298	695	203	17
Postpartum Care Rate	69.80%	70.41%	70.30%	72.27%	69.02%	72.24%	89.47%

A total of 2,211 PNRs were received into the Bright Steps program, a 29.49% of the total births in MY 2021.

Analysis

Member engagement with BSP increased in MY 2021 by 5.49%. See Table 5. BSP engagement is defined as a member who successfully is outreached to during the second, third or fourth (postpartum) trimester and completes a BSP assessment.

Table 5: BSP Engagementin MY 2020 and MY 2021

HEDIS MY	BSP Engagement (Includes members who did not receive timely PPC)	HEDIS Denominator	BSP Engagement Rate
2020	787	7,223	10.90%
2021	1,229	7,497	16.39%

Bright Steps Program (BSP) engagement is defined as successful outreach and assessment completion during the second, third or fourth (postpartum) trimester.

e. In MY 2021, 77.62% of members who engaged in BSP received timely postpartum care, compared withmembers who were not outreached at all (69.77%). This represents <1% increase from MY 2020. In addition, we analyzed members who were successfully outreached during the postpartum timeframe by BSP and 78.30% received timely postpartum care. While most members are under the care of a CPSP provider for services comparable to BSP, this finding suggests that BSP supports timely postpartum care.

f. Postpartum health reward participation rate (10.53%) among members who completed a Bright Steps postpartum assessment (n=940) was lower than MY 2020. Members who are achieving timely postpartum care may be opting not to participate in the reward program or the postpartum member health reward may not be a contributing factor to timely care. This is consistent with MY 2020.

g. Ongoing provider education and monitoring may support increased provider and Health Network awareness of the requirement to submit PNRs. The provider fax and mailing interventions did not drive a statistically significant improvement in the PNR submission rate.

h. Table 6 examines the Medi-Cal prenatal and postpartum care measure prospective rates. There is an increase in the September 2022 rates for prenatal care (80.30%) and postpartum care (64.36%) compared with the previous year's rate in the same month.

Table 6: MY 2022 Medi-Cal Prenatal and Postpartum Care Prospective Rate Results

HEDIS Prospective Rates	*Prenatal Care September 2021*	*Prenatal Care September 2022*	*Postpartum Care September 2021*	*Postpartum Care September 2021*
Numerator	5,427	5,436	4,228	4,357
Denominator	6,917	6,770	6,917	6,770
Rate	78.86%	80.30%	61.12%	64.36%

Claims/Encounters processed through September 2022. Prenatal and Postpartum Care are hybrid measures. Prospective rates are solely administrative and do not consider the hybrid sample.

Barriers

- BSP outreach is predominantly driven by a PNR to CalOptima Health. No notification form results in a missed opportunity for outreach, program engagement as well as resource linkage to members.
- Similarly, a late pregnancy notification results in a missed opportunity to provide support and critical information early in the member's pregnancy.
- The national COVID-19 PHE continued throughout MY 2021. This may have contributed to instances where members sought care in later stages of their pregnancy, thus impacting the timeliness of prenatal care and the timeliness in which a PNR was submitted to CalOptima Health. The PHE also led to reduced office visits due to the concerns about exposure for an expectant mother.
- BSP engages only a small portion of the HEDIS denominator. Engagement in the Bright Steps and Postpartum member health reward has increased, but the overall participation rates remain low among members who receive timely prenatal and postpartum care indicating that members may not be aware of or may not be taking advantage of these programs. Limited participation creates challenges in identifying the impact of these programs on completing timely care.
- Lack of Telephone Consumer Protection Act (TCPA) consent did not allow for member text message campaigns to launch in 2021. In addition, a limited number of members have TCPA consent on record, which places limitations on the members who can be outreached.
- Delays in claims and encounter data do not allow for the timely identification of a pregnancy or a delivery, which impacts the timeliness of member engagement.

Opportunities for Improvement

- Opportunities remain to increase promotion of and leverage the postpartum health reward to support timely postpartum care among members.
- As of April 1, 2022, the Medi-Cal postpartum benefit was expanded to one year after delivery. Subsequently the BSP also expanded services to offer additional member education to include maternal mental health, infant development and milestones among other important topics. This expansion may drive support during the postpartum experience.
- In MY 2022, the Spring and Summer Medi-Cal newsletter were programmed to include an article on the importance of prenatal care and advise members of the postpartum coverage expansion.
- As of July 1, 2022, DHCS added Community Health Worker (CHW) services as a Medi-Cal benefit. Maternal health quality metrics are being integrated into the organization's CHW scope of work. As

trusted members of the communities they serve, CHWs may bring opportunities for maternal and child health education, may identify and address member barriers to care, and facilitate the coordination of care with the member's OB/GYN provider.

- Beginning January 1, 2023, DHCS will be adding a doula benefit to the list of preventive services covered under Medi-Cal. Doula services include personal support throughout the pregnancy, childbirth and postpartum experience. The doula benefit may help maternal health outcomes for black and other persons of color while supporting safe and healthy deliveries. Doula care has been found to improve birth outcomes and reduce health disparities, by providing emotional and physical support to women during pregnancy, childbirth and the postpartum period. The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine found that continuous labor support is among the most effective tools to improve labor and delivery outcomes.[4]
- In MY 2022, prenatal and postpartum rates were analyzed by ZIP code and language. The results were used to develop targeted prenatal and postpartum social media and digital ad campaigns to cities with the lowest rates. The ads were developed in English, Spanish and Vietnamese and launched throughout the 2022 calendar year. These languages are consistent with high-volume threshold languages (see Table 3).
- CalOptima Health will continue to expand on the member communication and engagement strategy to include multimodal approach via: Medi-Cal member newsletters, paid digital media campaigns, PBS TV campaigns, CalOptima Health website, and live calls.
- CalOptima Health will continue to expand on a provider communication and engagement strategy to include a multimodal approach via the following platforms: Provider Press Newsletters, Provider Update, CCN Virtual Meetings, and collaboration with high volume/high opportunity providers. In MY 2022, an article that discusses PNR requirements went into the Fall Provider Press newsletter.
- Opportunities remain in linking maternal and child health together to drive positive health behaviors early in the pregnancy, which will carry through the entire pregnancy and infant's life. In MY 2022, BSP transitioned workflows to conduct well-child follow-up calls at the 6- and 12-month period in support of a member continuum of care and participated in six diaper-day community events with a focus on resource linkages to address social determinants of health. At the end of Q3 MY 2022, a maternal and child health proposal draft was finalized to support DHCS' Comprehensive Quality Strategy and Bold Goals that places maternal and child health as a priority for CalOptima Health.
- There are opportunities to close gaps in care and support reductions in health disparities by conducting targeted interventions such as a live-call campaign to racial/ethnic groups that have not completed a timely postpartum visit and who represent less than 5% of the total population. A live-call campaign intervention can include a member barrier analysis, support a positive member experience and encourage a positive relationship for the member with their primary care provider. However, because Hispanic members represent the largest group in volume for the PPC measure, interventions should continue to target this group.
- Opportunities remain in augmenting partnerships that support data exchange to facilitate the early identification of pregnancies as well as deliveries for early outreach, education and resource linkage.

[4] Caughey, A. B., Cahill, A. G., Guise, J. M., & Rouse, D. J. (2014). Safe prevention of the primary cesarean delivery. American Journal of Obstetrics and Gynecology, 210(3), 179–193.

Pediatric and Adolescent Well-Care Visits and Immunizations – Includes Well-Child Visits in the First 30 Months of Life (W30), Childhood Immunization Status (CIS Combo 10), Child and Adolescent Well-Care Visits (WCV) and Immunizations for Adolescents (IMA Combo 2)

Well-Child Visits in the First 30 Months of Life (W30)

Well-Child Visits in the First 30 Months of Life (W30) HEDIS measure is a part of the Medi-Cal Managed Care Accountability Set (MCAS), which is required to meet the minimum performance level (MPL) of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. MY 2021 is the first year reported rate. W30 evaluates the percentage of members who had the following number of well-child visits with a PCP during the past 15 months.

Interventions

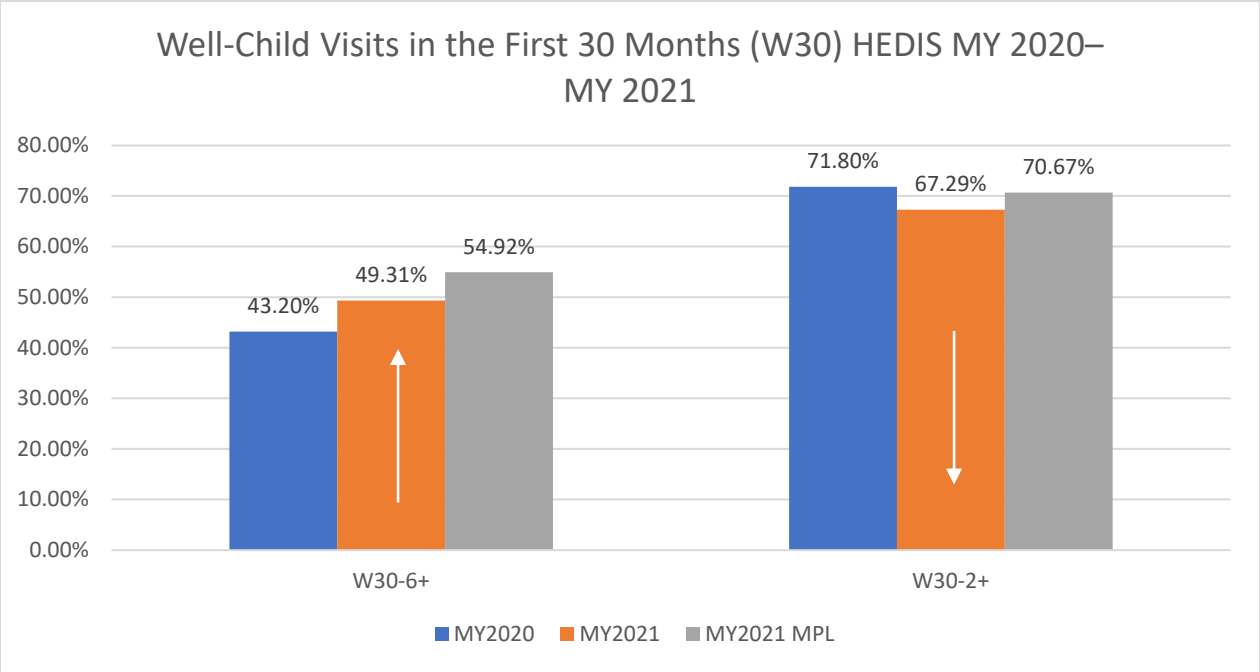
CalOptima Health has been committed to interventions that promote well-child visits. These include utilizing the BSP for follow-up phone calls, community newsletters and television advertisements.

Findings

CalOptima Health's HEDIS MY 2021 W30 did not meet MPL, see Figure 1 below. The W30-6+ rate (49.31%) increased by 6.1 percentage points and had significant improvement compared with last year and met the 33rd percentile (48.90%). The W30-2+ rate (67.30%) did not have significant improvement and decreased 4.5 percentage points compared with last year.

Figure 1 shows the increase in W30-6+ rate and a decline in W30-2+ rate compared with MY 2020. There was significant improvement in the W30-6+ rate but unfortunately did not meet the MPL of 54.92%. Additionally, W30-2+ did not meet the MPL of 70.67%. As such, improvement projects will stem from HEDIS MY 2021 results to ensure efforts are made to increase the W30 measure to meet MPL for HEDIS MY 2023.

Figure 1: Well-Child Visits in the First 30 Months of Life Final HEDIS MY 2020–MY 2021



W30 HEDIS MY 2020 was a display measure. W30 HEDIS MY 2021 was first year reported. MPL is the 50th percentile for Quality Compass Benchmarks.W30 is an administrative measure.

a. The Post Bright Steps Well-Child Follow-Up Call Initiative began in September 2020, and for HEDIS MY 2021, only W30-2+ members would be impacted by the outreach.

    i. 109 of 8,749 members were outreached via the Bright Steps Program Well-Baby Call Initiative. 72 unique members were successfully outreached, which means a live-person contact was made and the script questions were answered. 17 unique members were unsuccessfully outreached, which means no script questions were answered and no notes were captured by the Health Educator.

    ii. 44 of the 72 members who were successfully outreached completed at least six well-child visits in their first 15 months of life (W30-6+).

Table 1 examines the HEDIS MY 2021 W30-6+ rates by race/ethnicity, which includes the total population N=8,749, n (compliant members) = 4,314, yielding a final rate of 49.31%. 8 out of 10 subpopulations displayed did not meet MPL, with White, Chinese and Black members having the lowest rates (40.39%-41.98%). Moreover, in examination of ethnicities within the Asian population (denominator greater than 30) Chinese, Filipino and Korean members have a lower W30-6+ rate when compared to Vietnamese (67.14%) population who met MPL. This indicates an opportunity to develop interventions targeting subpopulations within each race category.

Table 1: Medi-Cal Well-Child Visits in the First 30 Months of Life (W30-6+), First 15 Months, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	*Hispanic*	*No Response*	*Other*	*White*	*Vietnamese*	*Black*	*Korean*	*Filipino*	*Asian/Pacific Islander*	*Chinese*
Numerator	2,225	750	528	330	333	34	31	23	20	14
Denominator	4,386	1,620	1,107	817	496	81	61	48	36	34
Rate	50.73%	46.30%	47.70%	40.39%	67.14%	41.98%	50.82%	47.92%	55.56%	41.18%
KPI, 50th Percentile	Not Met	Not Met	Not Met	Not Met	Met 75th	Not Met	Not Met	Not Met	Met 50th	Not Met

Table displays top 10 race/ethnicities with the highest denominator based on total population. W30 is an administrative measure.

Table 2 examines the HEDIS MY 2021 W30-2+ rates by race/ethnicity which includes the total population, N=12,025, n (compliant members) = 8,092, yielding a final rate of 67.29%. 7 of 10 subpopulations displayed did not meet MPL, with Black, White and Chinese members having the lowest rates (51.09%-–61.39%). Interestingly, for this latter submeasure of well-child visits between 15–30 months of life, Koreans and Filipino populations met the MPL but did not for the first 15 months. There is opportunity to develop a targeted intervention for the Black population as they were 19.58 percentage points from meeting the MPL.

Table 2: Medi-Cal, Well-Child Visits in the First 30 Months of Life (W30-2+), 15 to 30 Months, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	*Hispanic*	*No Response*	*White*	*Other*	*Vietnamese*	*Black*	*Korean*	*Chinese*	*Filipino*	*Asian/Pacific Islander*
Numerator	4,689	1,054	795	528	595	94	90	62	60	45
Denominator	6,799	1,597	1,326	917	709	184	122	101	80	65
Rate	68.97%	66.00%	59.95%	57.58%	83.92%	51.09%	73.77%	61.39%	75.00%	69.23%
KPI, 50th Percentile	Not Met	Not Met	Not Met	Not Met	Met 90th	Not Met	Met 50th	Not Met	Met 50th	Not Met

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts.

Analysis

- The Post Bright Steps Well-Child Follow-Up Call Initiative was implemented throughout MY 2021. Newborn members were identified through their parent or guardian who participated in the BSP. This allowed for an early identification and outreach to members prior to HEDIS reporting year. The call script included questions and guidance on both well-child visits and immunizations.
- CalOptima Health did not meet the goals set for W30 in MY 2021. As shown in Table 3, W30-6+ did not meet goal by 5.61 percentage points and W30-2+ did not meet goal by 7.13 percentage points.

Table 3: MY 2022 Medi-Cal W30 Goal

HEDIS Measure	*HEDIS MY 2021 Final Rate*	*MY 2021 Goal Rate*	*Variance*
Well-Child Visits in the First 30 Months of Life (W30-6+) 0–15 Months	49.31%	54.92%	-5.61 percentage points
Well-Child Visits in the First 30 Months of Life (W30-2+) 15–30 Months	67.29%	74.42%	-7.13 percentage points

Table displays the final HEDIS 2021 results and the goal for each measure.

Barriers

- The Bright Steps Well-Child Follow-Up Calls are limited to members whose parent or guardian participated in the BSP and are also CalOptima Health Medi-Cal members.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- Administratively, in the situation where members who completed well-child visits under their parent or guardian's medical record number and they are not CalOptima Health members, it is difficult to obtain those records for HEDIS reporting. This creates a data gap for members who receive care before establishing medical care with CalOptima Health.
- Since HEDIS captures members who turn either 15 months old or 30 months old for W30 in the measurement year, there is difficulty in identifying members timely to impact the first few recommended well-child visits by Bright Futures and American Academy of Pediatrics.
- The provider office had limited availability for scheduling appointments.
- The provider office did not have an appointment reminder system (e.g., email, text message or phone call reminder).
- The provider office wait times and total time spent in the office were too long.
- The provider office schedules did not allow for future well-child visits to be scheduled. The parent or guardian must call when the child gets closer to age-based well-child visit date.
- The member's well-child visit may have been replaced by a sick visit, which impacted their well-child visit schedule.
- The member's parent or guardian was unable to attend the well-child visit due to transportation limitations.
- The member's parent or guardian preferred to obtain care closer to home and with a trusted community partner (e.g., at a health fair).
- The member's parent or guardian may have been unaware about the timeliness and importance of well-child visits.
- The member's parent or guardian forgot to schedule and attend the well-child visits.

Opportunities for Improvement

Based on September 2022 Prospective Rate Report, W30-6+ (33.05%) and W30-2+ (67.46%) HEDIS rates are performing higher than last year, see Table 4. The latter measure, W30-2+ (15–30 months) has met MPL (65.83%). Opportunity remains to increase the W30 measure as the Quality Compass Benchmark was lowered due to all plans performing lower than MPL in MY 2021.

Table 4: MY 2022 Medi-Cal W30 Prospective Rates

	September 2021		*September 2022*		
HEDIS Measure	*Denominator*	*Rate*	*Denominator*	*Numerator*	*Rate*
W30-6+	8,768	28.30%	8,521	2,816	33.05%
W30-2+	12,046	63.31%	12,357	8,336	67.46%

Prospective Rates reflect claims/encounters processed through September 2022.

b. As an identified strategy to increase the W30 rate from MY 2021, a multimodal approach was implemented in MY 2022 that positively impacted the rate. Interventions and activities included telephonic outreach and call campaign, robocall campaigns, targeted mailing, mobile text messaging, targeted advertisements, and television advertisements.

c. A limitation of said interventions above was obtaining member consent for outreach. CalOptima Health will seek a concerted effort to increase TCPA consent so that more members may be included in robocall and text messaging campaigns.

d. Live-person telephonic call campaigns have proven to be effective in reaching members since there are less outreach limitations. It not only serves as a reminder to members, but CalOptima Health is able to obtain qualitative data on barriers to care. CalOptima Health will consider building an internal call center to conduct telephonic call campaigns more regularly to connect with members before they age-out of the measure.

e. Member surveys were conducted to obtain member feedback for areas of improvement.

Childhood Immunization Status (CIS-10)

Childhood Immunization Status – Combination 10 (CIS-10) HEDIS measure is a part of the Medi-Cal MCAS, which is required to meet the MPL of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. CIS evaluates the percentage of children 2 years of age who had the following vaccinations: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Combination 10 includes all vaccinations listed.

Interventions

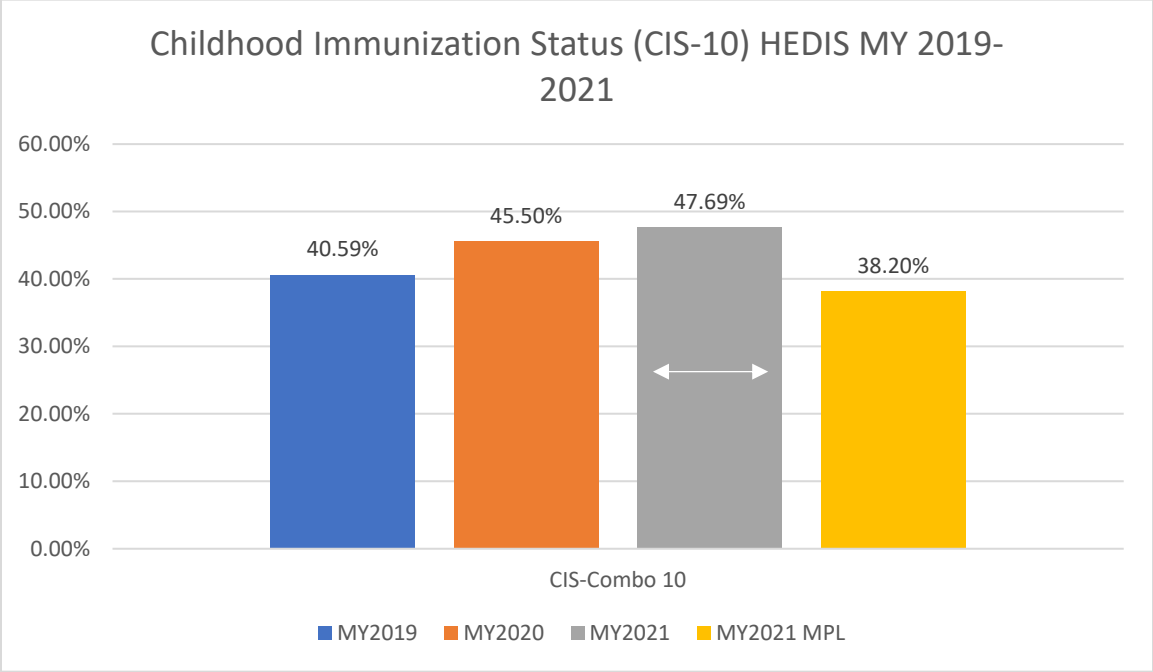
CalOptima Health has been committed to interventions that promote childhood immunizations. Interventions included utilizing the BSP for phone calls, community newsletters, television advertisements and social media campaigns.

Findings

a. CalOptima Health's HEDIS MY 2021 CIS-Combo 10 met MPL, see Figure 1 below. The CIS-Combo 10 rate (47.69%) increased by 2.19 percentage points but did not have significant improvement compared to last year and met the 75th percentile (45.50%).

b. Figure 1 shows the increase in CIS-Combo 10 rate compared to previous years. There was no significant improvement compared to MY 2020 but did meet the 75th percentile (45.50%).

Figure 1: Childhood Immunization Status Final HEDIS MY 2019–MY 2021



CIS-Combo 10 is a hybrid measure. CIS-Combo 10 HEDIS MY2019 rate was rotated: previous year's rate (2018) was reported. MPL is the 50th percentile for Quality Compass Benchmarks.

c. The Post Bright Steps Well-Child Follow-Up Call Initiative began in September 2020, for HEDIS MY 2021, no impact outcome is measured for CIS-Combo 10 since members who were outreached have not turned 2 years old in HEDIS MY 2021 reporting year.

d. Table 1 examines the HEDIS MY 2021 CIS-Combo 10 rates by race/ethnicity which includes the total population, N=13,082, n (compliant members) = 4,920, yielding a final rate of 37.61%. 4 of 10 subpopulations displayed did not meet MPL, identify Black members as having the lowest rate of 23.21%. There is opportunity to develop a targeted intervention for the Black population as they were 14.99 percentage points from meeting the MPL.

Table 1: Medi-Cal, Childhood Immunization Status (CIS-Combo 10), Combination 10, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	**Race/Ethnicity**									
HEDIS MY 2021	*Hispanic*	*No Response*	*White*	*Other*	*Vietnamese*	*Black*	*Korean*	*Chinese*	*Filipino*	*Asian/ Pacific Islander*
Numerator	2,774	696	429	390	378	39	51	43	30	33
Denominator	7,102	2,011	1,351	1,224	727	168	119	99	77	71
Rate	39.06%	34.61%	31.75%	31.86%	51.99%	23.21%	42.86%	43.43%	38.96%	46.48%
KPI, 50th Percentile	Met 50th	Not Met	Not Met	Not Met	Met 75th	Not Met	Met 50th	Met 50th	Met 50th	Met 75th

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts.

Analysis

a. The Post Bright Steps Well-Child Follow-Up Call Initiative was implemented throughout MY 2021. Newborn members were identified through their parent or guardian who participated in the BSP. This allowed for an early identification and outreach to members prior to HEDIS reporting year. The call script included questions and guidance on both well-child visits and immunizations.

b. CalOptima Health did not meet the goal for CIS-Combo 10 in MY 2021. As shown in Table 3, CIS-Combo 10 did not meet the goal by 1.89 percentage points.

Table 2: MY 2022 Medi-Cal CIS-Combo 10 Goal

HEDIS Measure	*HEDIS MY 2021 Final Rate*	*MY 2021 Goal Rate*	*Variance*
Childhood Immunization Status (CIS) Combination 10	47.69%	49.58%	1.89 percentage points

Barriers

- The Bright Steps Well-Child Follow-Up Calls are limited to members whose parent or guardian participated in the BSP and are also CalOptima Health Medi-Cal members.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- CIS-Combo 10 includes the completion of 10 vaccine types and its respective doses. If a member is receiving their vaccinations off schedule, it decreases the likelihood of completing them within the CIS timeframe.
- Since HEDIS captures members who turn 2 years old for CIS in the measurement year, there is difficulty in identifying members timely to impact the first few recommended vaccinations by Bright Futures and American Academy of Pediatrics.
- The provider office had limited availability for scheduling appointments, may have long office wait times and may not have an appointment reminder system in place.
- The provider office schedule does not allow for future immunizations to be scheduled. The parent or guardian must call when it gets closer to age-based well-child visit date.

- The member's parent or guardian prefers to obtain care closer to home and with a trusted community partner (e.g., at a health fair).
- The member's parent or guardian is unaware of the timeliness and importance of vaccinations or forgot to schedule and attend well-child visits to obtain vaccinations for their child.
- The member's parent or guardian is fearful of the vaccinations or refuses the provider's recommendation for vaccinations.

Opportunities for Improvement

- Based on September 2022 Prospective Rate Report, CIS-Combo 10 (30.57%) HEDIS rates are performing higher than last year and has not met MPL (34.79%), see Table 3. Opportunities remain to increase the CIS-Combo 10 rate.

Table 3: MY 2022 Medi-Cal Prospective Rates

	September 2021		*September 2022*		
HEDIS Measure	*Denominator*	*Rate*	*Denominator*	*Numerator*	*Rate*
Childhood Immunization Status (CIS) Combination 10	12,702	30.26%	11,789	3,604	30.57%

Prospective Rates reflect claims/encounters processed through September 2022.

- As an identified strategy to increase CIS-Combo 10 rate from MY 2021, a multimodal approach was implemented in MY 2022, which has shown to positively impact the rate. Interventions and activities included member telephonic outreach, targeting mailings, mobile texting, targeted advertisements and television advertisements.
- A limitation of the interventions was due to the challenge in obtaining member consent for outreach. CalOptima will seek a concerted effort to obtain more TCPA consents so more members can be included in robocall campaigns and text message campaigns.
- Since Well-Child Visits in the First 30 Months of Life (W30) and Childhood Immunization Status (CIS) populations overlap there are opportunities to complete singular interventions to target both populations.
- Additionally, live-person telephonic call campaigns have proven to be effective in reaching members since there are fewer outreach limitations. It not only serves as a reminder to members, but CalOptima Health is able to obtain qualitative data on barriers to care. CalOptima Health will consider building an internal call center to conduct telephonic call campaigns more regularly to connect with members before they age out of the measure.

Child and Adolescent Well-Care Visits (WCV)

Child and Adolescent Well-Care Visits (WCV) HEDIS measure is a part of the Medi-Cal MCAS, which is required to meet the MPL of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. WCV evaluates the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Interventions

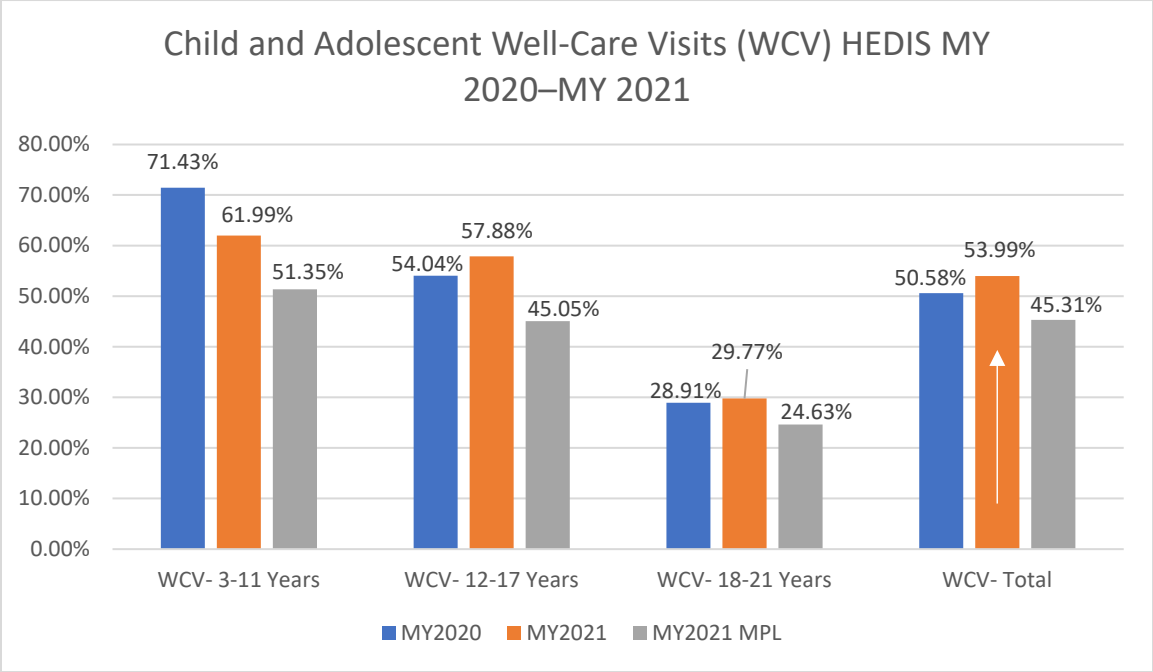
CalOptima Health has been committed to interventions that promote child and adolescent Well-Care Visits. Interventions included member and community newsletters, robocall campaigns and social media campaigns.

Findings

a. CalOptima Health's HEDIS MY 2021 WCV-Total met MPL, see Figure 1 below. The WCV-Total rate (53.99%) increased by 3.14 percentage points and had significant improvement compared to last year. WCV-Total met the 75th percentile (53.83%).

b. Figure 1 shows an increase in WCV-Total rate compared to MY 2020. There was significant improvement compared to MY 2020 and met the 75th percentile (53.83%).

Figure 1: Child and Adolescent Well-Care Visits Final HEDIS MY 2020–MY 2021



WCV HEDIS MY 2020 was a display measure. WCV HEDIS MY 2021 was first year reported. WCV-Total is reported and held to the MPL. MPL is the 50th percentile for Quality Compass Benchmarks. WCV is an administrative measure.

c. 45,649 of 302,266 WCV members received the Health Guide 3-6 Newsletter Mailing. Of those 20,782 members completed their well-care visit after receiving the mailing.

d. 30,163 of 302,266 WCV members were included in the DHCS Preventative Outreach IVR campaign. 2,277 members successfully played message to live voice or received voice mail and completed their well-care visit after receiving this campaign.

e. Table 1 examines the HEDIS MY 2021 WCV-Total rates by race/ethnicity which includes the total population, N=302.275, n (compliant members) = 163,213, yielding a final rate of 53.99%. 3 of 10 subpopulations displayed did not meet MPL, identifying White and Black members as having the lowest rates of 39.14% and 42.07%, respectively. There is opportunity to develop a targeted intervention for the White and Black population to meet the MPL.

Table 1: Medi-Cal, Child and Adolescent Well-Care Visits (WCV), Total, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	**Race/Ethnicity**									
HEDIS MY 2021	*Hispanic*	*White*	*Vietnamese*	*No Response*	*Other*	*Korean*	*Black*	*Filipino*	*Chinese*	*Asian/Pacific Islander*
Numerator	110,277	13,989	14,817	9,332	4,390	2,851	2,051	1,469	1,350	901
Denominator	192,550	35,744	23,937	18,023	9,993	5,436	4,875	3,039	2,893	1,965
Rate	57.27%	39.14%	61.90%	51.78%	43.93%	52.45%	42.07%	48.34%	46.66%	45.85%
KPI, 50th Percentile	Met 75th	Not Met	Met 75th	Met 50th	Not Met	Met 50th	Not Met	Met 50th	Met 50th	Met 50th

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts.

Analysis

a. It is undetermined if there's a correlation between the Health Guide 3-6 Newsletter Mailing and the DHCS Preventative Outreach IVR campaign having an impact on the WCV rate, however, 1,338 members received both interventions and were compliant. WCV 3-11 Years Denominator: 133,884

    i. 1,338 / 133,884 = 1.00% impact to the submeasure, WCV 3-11 Years

b. CalOptima Health met the goal set for MY 2021. As shown in Table 2, WCV met the goal set by 0.16 percentage points.

Table 2: MY 2022 Medi-Cal WCV Goal

HEDIS Measure	*HEDIS MY 2021 Final Rate*	*MY 2021 Goal Rate*	*Variance*
Child and Adolescent Well-Care Visits (WCV) Total	53.99%	53.83%	+0.16 percentage points

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Barriers

- The WCV population is large at 302,266 members. It is difficult to implement an intervention that will impact the larger population to improve the HEDIS rate.
- Despite IVR campaigns having the capacity for a large reach, landline phone numbers limit the number of members who can receive the IVR message.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- The provider offices have limited availability for scheduling appointments, may not have an appointment reminder system and may have long office wait times.
- The member's well-care visit is replaced by a sick visit, which may lead to the parent or guardian forgetting to schedule another well-care visit.
- The member's parent or guardian is unable to attend well-care visit due to transportation limitations.
- The member's parent or guardian prefers to obtain care closer to home and with a trusted community partner (e.g., at a health fair).

- The member's parent or guardian was unaware about the timeliness and importance of well-care, or forgot to schedule and attend well-care visits.
- Members may be reluctant to attend well-care visits as it's not required to attend school. Incoming kindergarteners are the exception.

Opportunities for Improvement

a. Based on September 2022 Prospective Rate Report, WCV-Total (30.05%) HEDIS rates are performing higher than last year but have not met MPL (48.93%), see Table 3. Opportunities remain to increase the WCV rate.

Table 3: MY 2022 Medi-Cal WCV Prospective Rates

	September 2021		*September 2022*		
HEDIS Measure	*Denominator*	*Rate*	*Denominator*	*Numerator*	*Rate*
Child and Adolescent Well-Care Visits (WCV) Total	305,149	32.58%	317,273	111,196	35.05%

Prospective Rates reflect claims/encounters processed through September 2022.

b. As an identified strategy to increase WCV rate from MY 2021, a multimodal approach has been implemented in MY 2022 that has shown to positively impact the rate. Interventions and activities included newsletters, robocall campaigns, mobile text message campaigns, targeted advertisements, and television advertisements.

c. A limitation of the interventions was due to the challenge in obtaining member consent for outreach. CalOptima will seek a concerted effort to obtain more TCPA consents so more members may be included in robocall campaigns and text message campaigns especially as electronic outreach is feasible for the large population of the WCV HEDIS measure.

d. Since Child and Adolescent Well-Care Visits (WCV), Lead Screening in Children (LSC), Immunizations for Adolescents (IMA) have overlapping member populations, there are opportunities to do a concerted effort for interventions to include all these members.

e. Opportunities to collaborate with community-based organizations (CBOs) and school districts to promote well-care visits for students of all ages. Past community events proved parents and/or guardians see their child's school and CBOs as trusted resources and are more likely to respond and follow through with the guidance.

Immunizations for Adolescents (IMA-2)

Immunizations for Adolescents (IMA) HEDIS measure is a part of the Medi-Cal MCAS, which is required to meet the MPL of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. IMA evaluates the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Interventions

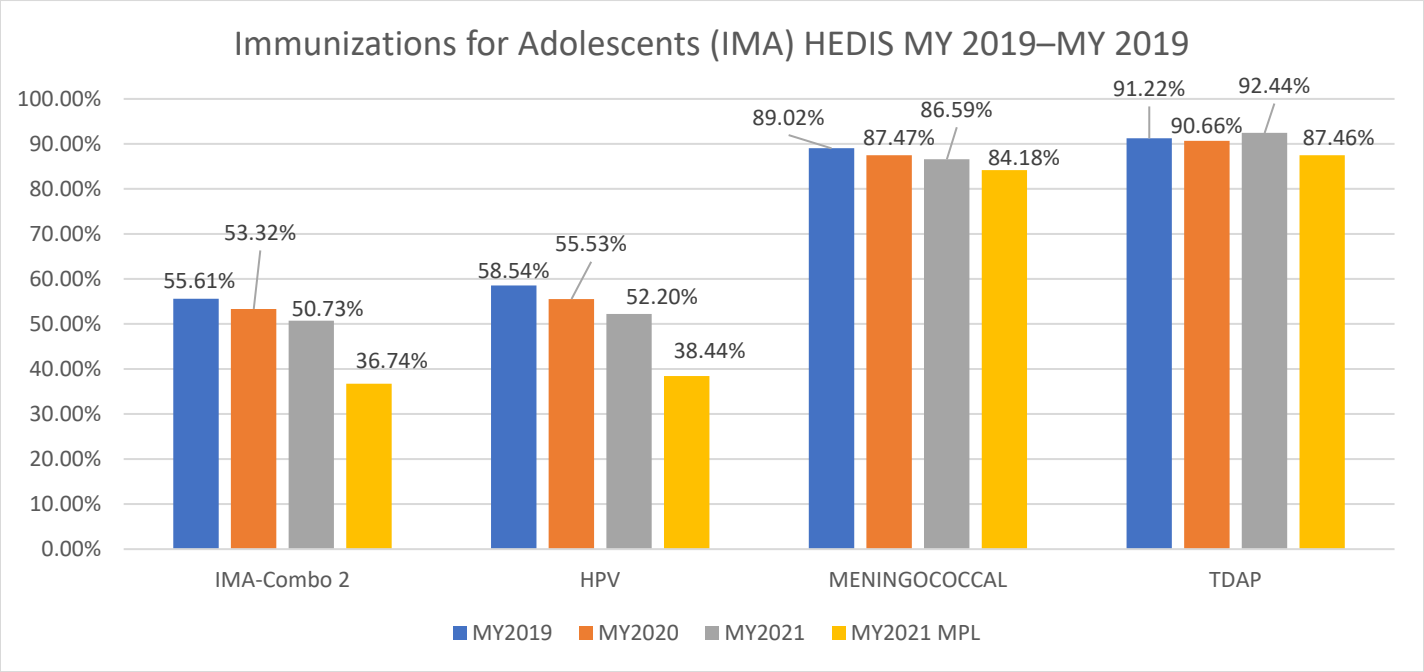
CalOptima Health supports interventions that promote adolescent immunizations. Interventions included back-to-school vaccination events, member and community newsletters, website promotion and social media campaigns.

Findings

a. CalOptima Health's HEDIS MY 2021 IMA-Combo 2 met MPL (36.74%), see Figure 1 below. The IMA-Combo 2 rate (50.73%) decreased by 2.59 percentage points and did not have significant improvement compared to last year. IMA-Combo 2 met the 90th percentile (50.61%).

b. Figure 1 shows a decrease in IMA-Combo 2 rate compared to previous years. There was no significant improvement compared to MY 2020 but did meet the 90th percentile (50.61%).

Figure 1: Immunizations for Adolescents Final HEDIS MY 2019–MY 2021



IMA is a hybrid measure. MPL is the 50th percentile for Quality Compass Benchmarks. IMA-Combo 2 is reported and held to the MPL. MPL is the 50th percentile for Quality Compass Benchmarks.

c. In summation of all the Back-To-School Vaccination Event participants, only 16 fell in the IMA denominator. Furthermore, only 2 of the 16 members became compliant after attending the event.

d. 3,722 CalOptima Health Medi-Cal members ages 11–17 were included in the DHCS Preventative Outreach IVR Campaign. Only 2,256 of 17,445 IMA members received robocall. Of those, 398 members successfully played a message to live voice or received voice message. Nine members completed their vaccinations series after receiving the outreach.

e. Table 1 examines the HEDIS MY 2021 IMA-Combo 2 rates by race/ethnicity, which includes the total population, N=17,855, n (compliant members) = 8,127, yielding a final rate of 45.52%. 5 of 10 subpopulations displayed did not meet MPL, with White, Black and Asian/Pacific Islanders having the lowest rates. There is opportunity to develop a targeted intervention for these identified subpopulations to help meet the MPL.

Table 1: Medi-Cal, Immunizations for Adolescents (IMA-Combo 2), Combination 2, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Korean	Black	Chinese	Filipino	Asian/Pacific Islander
Numerator	5,914	522	835	261	109	129	74	66	74	43
Denominator	12,240	1,878	1,363	735	333	305	302	160	160	125
Rate	48.32%	27.80%	61.26%	35.51%	32.73%	42.30%	24.50%	41.25%	46.25%	34.40%
KPI, 50th Percentile	Met 75th	Not Met	Met 90th	Not Met	Not Met	Met 50th	Not Met	Met 50th	Met 75th	Not Met

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts. IMA-Combination 2 includes adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Analysis

a. It is undetermined if there's a correlation between the DHCS Preventative Outreach IVR campaign having an impact on the IMA-Combo 2 rate.

b. CalOptima Health met the goal set for IMA-Combo 2 in MY 2021. As shown in Table 2, IMA-Combo 2 met the goal set by 0.12 percentage points.

Table 2: MY 2022 Medi-Cal IMA-Combo 2 Goal

HEDIS Measure	*HEDIS MY 2021 Final Rate*	*MY 2021 Goal Rate*	*Variance*
Immunizations for Adolescents (IMA) Combination 2	50.73%	50.61%	+0.12%

Table displays the final HEDIS 2021 results and the goal for each measure.

Barriers

- Back-To-School Vaccination Events required collaboration across multiple organizations with high reach potential, but low impact. As discussed above, only 16 members fell in the IMA denominator.
- With the availability of the COVID-19 vaccine in 2021, clinics' availability to support Back-To-School Vaccination events was limited as they were in process of operationalizing internal vaccine clinics.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- The provider offices have limited availability for scheduling appointments, did not have an appointment reminder system or the wait times were too long.
- The provider office schedule did not allow for future immunizations to be scheduled. The parent or guardian had to call the office to schedule the appointment when the child was closer to the age-based well-child visit date.
- The member's parent or guardian preferred to obtain care closer to home and with a trusted community partner (e.g., at a health fair).
- The member's parent or guardian was unaware of the timeliness and importance of vaccinations.
- The member's parent or guardian forgot to schedule and attend well-child visits to obtain vaccinations for their child.

- The member's parent or guardian or the child had a fear of vaccinations or refused the provider's recommendation for vaccinations.

Opportunities for Improvement

a. Based on September 2022 Prospective Rate Report, IMA-Combo 2 (44.34%) HEDIS rates are performing lower than last year and have met the MPL (35.04%), see Table 3. IMA-Combo 2 has met the 66th percentile (39.16%). Opportunities remain to increase the IMA-Combo 2 rate as MY 2022 performance is lower than MY 2021.

Table 3: MY 2022 Medi-Cal IMA-Combo 2 Prospective Rates

	September 2021		*September 2022*		
HEDIS Measure	*Denominator*	*Rate*	*Denominator*	*Numerator*	*Rate*
Immunizations for Adolescents (IMA) Combination 2	17,464	45.68%	17,574	7,793	44.34%

Prospective Rates reflect claims/encounters processed through September 2022.

b. As an identified strategy to increase IMA rate from MY 2021, a multimodal approach has been implemented in MY 2022 that has shown to positively impact the rate. Interventions included back-to-school vaccination events, member and community newsletters, website promotion and social media campaigns.

c. There was a limitation of the interventions due to the challenge in obtaining member consent for outreach. CalOptima Health will seek a concerted effort to obtain more TCPA consents so that more members may be included in robocall campaigns and text message campaigns.

d. Additionally, live-person telephonic call campaigns have proven to be effective in reaching members since there are fewer outreach limitations. It not only serves as a reminder to members, but CalOptima Health is able to obtain qualitative data on barriers to care. CalOptima Health will consider building an internal call center to conduct telephonic call campaigns more regularly to connect with members before the member ages out of the measure.

e. CalOptima Health has opportunities to collaborate with CBOs and school districts to promote vaccinations for students. Past community events proved parents and/or guardians see their child's school and CBOs as trusted resources and are more likely to respond and follow through with the guidance.

Blood Lead Screening (BLS) Lead Screening in Children (LSC)

Lead Screening in Children (LSC) is a hybrid HEDIS and MCAS measure that is currently not held to the MPL. LSC measures the percentage of children who are 2 years of age and had one or more capillary or venous blood test for lead poisoning by their second birthday.

Beginning MY 2022, managed care plans (MCPs) will be held to the MPL. In addition, through All Plan Letter (APL) 20-016: Blood Lead Screening in Young Children, DHCS issued regulatory requirements for MCPs to ensure timely BLS among eligible child members. APL mandates differ from HEDIS and require two BLS, one at 12 months and a second at 24months of age with catch-up testing if these recommendations are not met.

CalOptima Health has engaged in efforts to ensure compliance with the DHCS APL 20-016 and increase the BLS rates through various provider and member-based efforts that emphasize the importance of timely BLS. Meeting the testing mandates outlined in the APL will support improved testing rates for the LSC HEDIS measure, thus blood lead testing is an opportunity for CalOptima Health to prioritize pediatric preventive care measures such as LSC.

Interventions

- Spring 2021 Medi-Cal Newsletter: April 2021 was mailed to all 535,741 head of household members in seven threshold languages.
- Health Guide 3-6 Newsletter and “How Protect Your Family from Lead Poisoning” handout: April 2021 was mailed to 47,901 Medi-Cal children ages 3–6.
- Social Media Engagement: October 2021 Social media post on Facebook, Instagram and Twitter during National Lead Poisoning Prevention week.
- Be Aware of Lead Poster: During October 6–29, 2021, 325 English, Spanish and Vietnamese posters were distributed to 65 high-volume provider offices that described the health effects of lead, who must be screened for lead and preventing exposure to lead.
- DHCS Blood Lead Postcard Resource Guide: November 2021

- Quarterly BLS Gap Reports: April 2021
    i. In accordance with regulatory and operational requirements, the BLS gap reports were sent to all Health Networks. The first gap report was sent in April 2021 and identified children 6–72 months of age who have not been screened for lead as recommended. CalOptima Health also provided information to the Health Networks through Provider Update, Provider Press Newsletter, Quality 1:1 quarterly meetings with Health Networks.

Findings

b. The HEDIS LSC measure was not held to MPL during MY2021. The final HEDIS rate was 63.99%.

c. In reviewing the testing rate by ethnicity for the LSC measure, see Table 1, Hispanic child members represent the majority of the child population (54.28%) and had a 64.19% testing rate. Black child members represent 1.28% of the child population, however, were among the groups that had the lowest testing rates (42.86%). Additionally Chinese, Filipino and Asian/Pacific Islander child members represent less than 1% of the total population but were among the groups with the lower testing rates.

Table 1: MY 2021 LSC HEDIS Results by Ethnicity

Hybrid	**Ethnicity**										
HEDIS MY 2021	*Hispanic*	*No response*	*White*	*Other*	*Vietnamese*	*Black*	*Korean*	*Chinese*	*Filipino*	*Asian/ Pacific Islander*	*Total*
Numerator	4,559	1,080	655	667	480	72	83	59	45	30	7,802
Denominator	7,102	2,011	1,351	1,224	727	168	119	99	77	71	13,082
Rate	64.19%	53.70%	48.48%	54.49%	66.02%	42.86%	69.75%	59.60%	58.44%	42.25%	59.64%
% of Total Population	54.29%	15.37%	10.33%	9.36%	5.56%	1.28%	0.91%	0.76%	0.59%	0.54%	59.63%

Table A displays top 10 ethnicities with the highest denominator based on total population. LSC is a hybrid measure. The total rate does not indicate the final HEDIS rate.

d. Claims from January 1, 2021–May 23, 2022, related to blood lead diagnosis were analyzed. Out of 199 claims, 95 (47.7%) members have diagnosis Z77.011 – Contact with and (suspected) exposure to lead. Santa Ana (15.85%), Anaheim (14.73%) and Laguna Beach (10.52%) are the top three geographic areas of members being diagnosed with “contact with/and suspected exposure to lead.” Results are consistent with the environmental risk factors present in the communities of Santa Ana and Anaheim as a result of pre-1978 housing.

e. One research study[11] analyzed the concentration of lead in soil samples throughout Santa Ana and concluded that census tracts with lower-income households have higher concentrations of lead in the soil. In addition, 11 census tracts within Santa Ana were identified as high risk for lead exposure. In August 2022, lead testing rates were analyzed using May 2022 prospective rates, and it was found that 39.1% of children living in these 11 high risk census tracts remained untested.

f. Lead paint has historically been the greatest source of lead exposure, but children can be exposed to lead through additional sources. In one study[12], researchers mapped historical roads, traffic patterns and housing in Santa Ana. They found greater concentrations of lead in areas that experienced higher traffic volumes over a longer period of time. It was concluded that concentration of lead in soil is due to pollution from vehicle emissions, which poses a risk for lead exposure and lead poisoning.

a. Beginning MY 2022, the HEDIS LSC measure will be held to the MPL. As of September 2022, the LSC prospective rate was 58.94%, which is a 1.51 percentage points higher than the September 2021 prospective rate of 57.43%. See Table B.

Table 2: MY 2022 Medi-Cal LSC Prospective Rate Results

HEDIS Prospective Rates	*September 2021*	*September 2022*
Numerator	7,295	6,949
Denominator	12,702	11,789
Rate	57.43%	58.94%

Claims/Encounters processed through September 2022. LSC is a hybrid measure. Prospective Rates are solely administrative and do not take into account hybrid sample.

2. Analysis

a. The first quarterly BLS gap reports issued in April 2021 contained data from January through March 31, 2021. The BLS gap report identified child members who have not been screened for lead in accordance with the California Code of Regulations. This is intended to support Health Networks with their efforts to close gaps in blood lead screening.

b. Multiple interventions were focused on driving member awareness and providing education related to BLS. It is key to continue to drive member education efforts, but there are opportunities to expand on interventions that focus on providers and high-volume offices. In addition, there are opportunities to better understand the potential systematic barriers that may be preventing members from getting a blood lead test.

c. September 2022 Prospective Rates are higher than the same time in September 2021. Lower prospective rates in 2021 may be a result of the impact of the COVID-19 pandemic on well-child visit attendance and subsequently blood lead testing.

[11] Masri S, LeBrón A, Logue M, Valencia E, Ruiz A, Reyes A, Lawrence JM, Wu J. Social and spatial distribution of soil lead concentrations in the City of Santa Ana, California: Implications for health inequities. Sci Total Environ. 2020 Nov 15;743:140764. doi: 10.1016/j.scitotenv.2020.140764. Epub 2020 Jul 6. PMID: 32663692; PMCID: PMC7492407

[12] Rubio, J M, Masri, S., LeBrón, A., Torres, I .R., Sun, Y., Villegas, K., Flores, P., Logue, M.D., Reyes A., Lebron. A., Wu, J. Use of historical mapping to understand sources of soil-lead contamination: Case study of Santa Ana, CA. *Environmental Research*. 22 Sept. *212.* doi: https://doi.org/10.1016/j.envres.2022.113478

Barriers

- On July 6, 2021, Magellan Diagnostics issued a recall on LeadCare II, LeadCare Plus and LeadCare Ultra Blood Lead Tests. The recall was expanded two additional times. Distribution of the products did not resume until March 30, 2022. This recall had the potential to contribute to systematic barriers with the shortage of blood lead testing supplies and pose additional challenges with the distribution of available supplies. In addition, the recall may have contributed to member barriers if the provider was not able to perform a blood lead test in office and required the member to go to a lab for testing.
- Laboratories may have reduced their ability for testing due to limited point of care testing supplies as a result of the Magellan Diagnostics recall.
- Providers may not have had the capability to conduct point of care testing for lead in their offices and must refer members to complete a lead test in a laboratory.
- The national COVID-19 PHE continued throughout MY 2021. Since the onset of the pandemic, there has been a decrease in well-child visits, which has led to significant delays in the provision of recommended screenings including lead testing. There are cohorts of children who remain behind on these regular routine visits or may follow an alternative schedule.
- Parents or guardians of children may opt not to complete a lead screening because they may be unaware of the importance of blood lead testing or the recommended testing cadence at 12 and 24 months of age. Parents or guardians may also have concerns related to the physical discomfort associated with testing.
- The Telephone Consumer Protection Act (TCPA) consent restrictions did not allow for member text message campaigns to launch in 2021. In addition, a limited number of members have TCPA consent on record, which places limitations on the members who can be outreached.
- Low-income communities face the burden of geospatial barriers that increased the risk of lead exposure. Disproportionate rates of lead exposure are the result of the lack of regulations related to lead, discrimination in housing and poor housing quality, and high concentrations of lead in the soil that are not being addressed. Lack of effective policies and investment efforts to address environmental factors will continue to result in persistent lead, heightened exposure risk and ongoing health consequences as a result of exposure.

Opportunities for Improvement

- The LSC measure was not held to MPL in MY 2021, however the measure will be held to MPL in MY 2022. In addition, DHCS issued APL 20-016 in November 2020 to mandate two blood lead tests with the opportunity to complete catch up testing through 72 months of age. Meeting the regulatory requirements for testing will support the LSC measure that mandates one test at minimum, thus blood lead testing should be a high priority for quality initiatives.
- Exposure to lead is an environmental justice and health equity issue. Research indicates that lead exposure disproportionately affects low-income communities and children of color. Addressing lead screening rates provides an opportunity to address health equity issues, however it requires a multiprong approach. Blood lead testing is the best and only way to identify lead exposure in children.
- In Q3 of MY 2022, CalOptima Health conducted in-person (n=28) and telephonic (n=113) barrier analysis among parents/guardians of child members to understand the root causes that influence blood lead testing or the lack thereof. Out of the 28 parents surveyed, 20 (71.42%) tested for lead, and 18 (85.71%) of those that tested did so as a result of a provider recommendation. Conclusion: Providers are an important factor for childhood blood lead testing. Out of the 113 parents surveyed, 57 (50.44%) tested for lead, 45 (39.82%) did not test for lead and 27 (51.11%) of those who did not test did not know about lead testing. In conclusion, opportunities exist for member education efforts to advise of the importance of blood lead screenings.

- Opportunities remain to conduct a provider barrier analysis to understand their perception of the factors that influence blood lead testing among child members or the lack thereof.
- CalOptima Health will continue to expand on the member communication and engagement strategy to include multimodal approach via: Medi-Cal member newsletters, texting, robocalls, paid digital media campaigns, PBS TV campaigns, CalOptima Health website and live calls.
- CalOptima Health will continue to expand on a provider communication and engagement strategy to include a multimodal approach via: Provider Press Newsletters, Provider Update, Continuing Medical Education (CME) events, and collaboration with high-volume/high-opportunity providers.
- Opportunities remain to tailor initiatives to untested members. Testing rates were analyzed by ZIP code and languages and were used to develop targeted social media and digital ad campaigns in English, Spanish and Vietnamese that launched throughout MY 2022.
- There are opportunities to close gaps in care and support reduce health disparities by conducting targeted interventions such as a live call campaign to racial/ethnic groups that are untested per the LSC measure and who represent less than 5% of the total population. A live call campaign intervention can include a member barrier analysis, support a positive member experience and encourage a positive relationship with their PCP. However, because Hispanic members represent the largest group in volume, interventions should continue to target this group.
- The BSP is transitioning workflows to conduct well-child follow-up calls at the 6- and 12-month period to parents who participated in the BSP to support a continuum of care. BSP follow-up calls will include educating parent/guardian on testing, analyzing potential barriers for testing and discussing potential sources of lead.
- In MY 2022, LSC was included in the Pay 4 Value (P4V) program to drive Health Network performance. Inclusion may support the increase of blood lead screening rates.
- In MY 2022, TCPA consent was resumed and a robocall campaign was conducted in July 2022 to remind members who were untested, per the LSC measure, to get a blood lead test. Additionally, a text campaign launched December 2022 and advised parents/guardians of the health effects associated with lead exposure and encouraged blood lead testing.
- Opportunities remain for the organization to expand on the modalities to obtain member TCPA consent to maximize member engagement.
- In October 2022, a process was implemented among Health Networks to attest to operational and regulatory requirements, which include retrieving, reviewing and distributing quarterly gap report data to providers. Provider are urged to test these members for lead. Additional attestation components include ensuring the documentation of the refusals of blood lead testing and following standards of care for testing and follow-up care.
- CalOptima Health will enhance quarterly blood lead reports to include a provider summary of member testing rates to support Health Networks with analysis and continued monitoring of lead screening rates by providers.
- Opportunities remain to offer a member health reward for members who complete a blood lead test at 12 and 24 months. Lead testing is interdependent with well-child visits. Offering a member health reward may also drive the completion of pediatric quality measures.
- A new Community Health Worker (CHW) benefit may bring opportunities for member education on lead testing, identify and address member barriers to testing, and facilitate the coordination of care with member's PCPs.

Member Experience (CAHPS)

CalOptima Health annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima Health 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.

Overview of Consumer Assessment of Healthcare Providers and Systems (CAHPS)

a. CalOptima Health monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and health network. The achievement score is the calculation of positive responses, typically identified as "Usually" or "Always" or rated top scores of "9 or 10."

b. Although the COVID-19 pandemic may have contributed, CalOptima Health's response rates have continued to decrease in the past few years despite oversampling efforts. A lower response rate in 2022 has led to CalOptima Health's inability to report a valid adult CAHPS rate to NCQA for five measures due to a small denominator (N<100). As a result, CalOptima Health is further increasing its oversample in the next survey cycle.

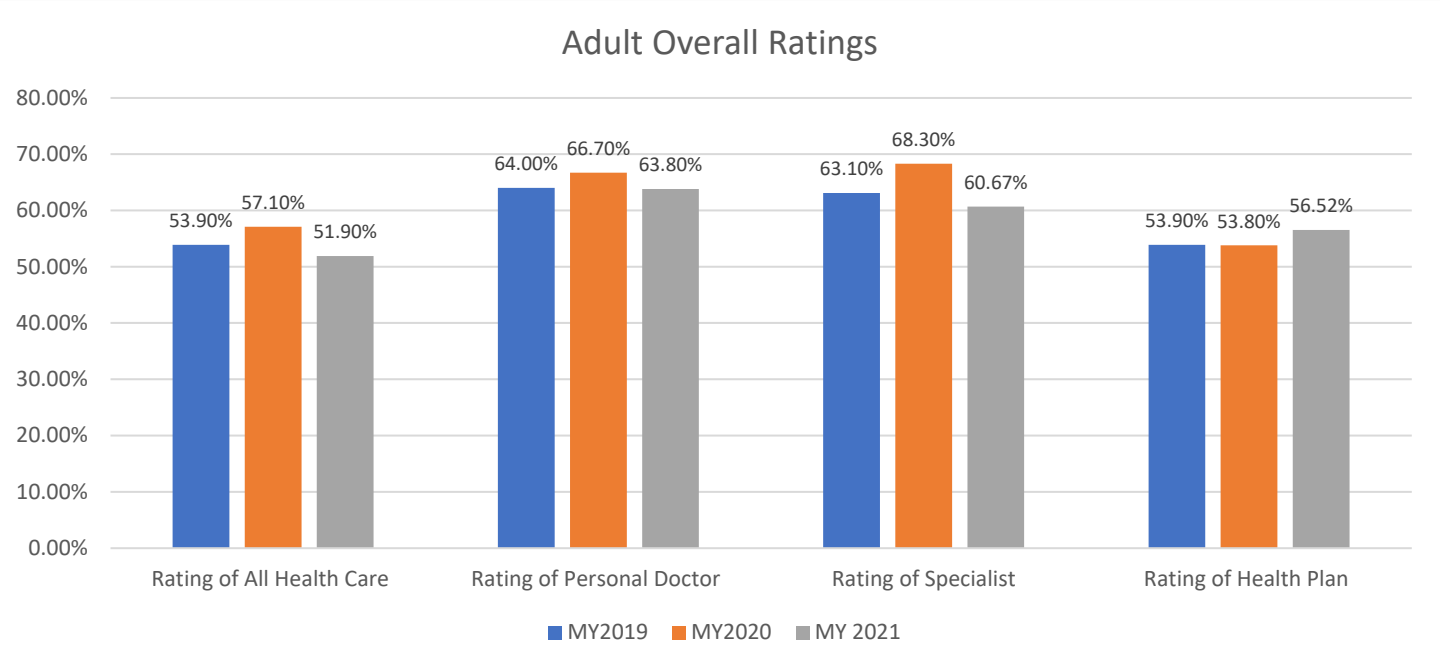
c. To align with NCQA's Health Plan Ratings methodology, CalOptima Health benchmarks the plan's CAHPS performance against the 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles for Medi-Cal. For OneCare, the Medicare Star Rating cut points will be used to benchmark CAHPS performance.

Findings: Grievances and CAHPS Survey Results

The following graphs display CAHPS survey results for MY 2021.

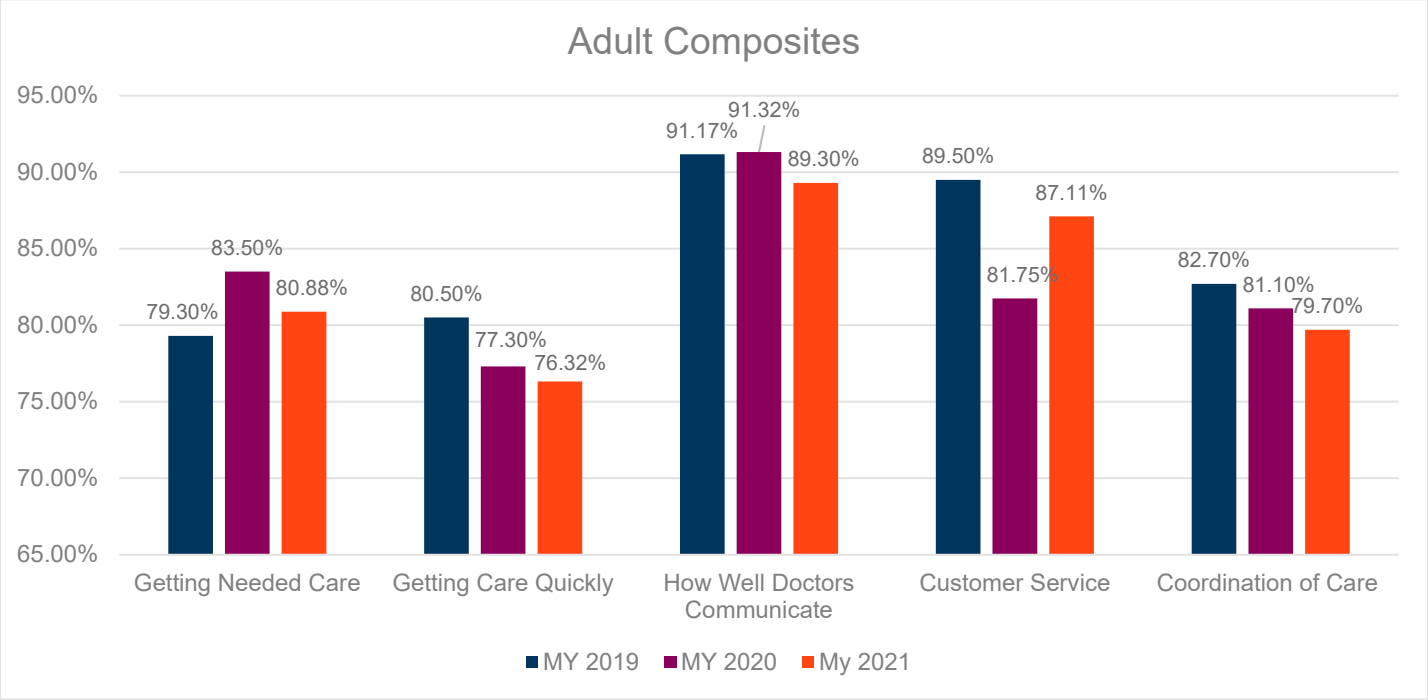
Medi-Cal Adult CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	51.9%	49.34	54.22	58.77	63.02
Rating of Personal Doctor	63.8%	61.79	65.34	71.14	75
Rating of Specialist Seen Most Often	*60.67%	61.94	66.34	70	75.47
Rating of Health Plan	56.52%	53.85	59.78	64.94	70.09

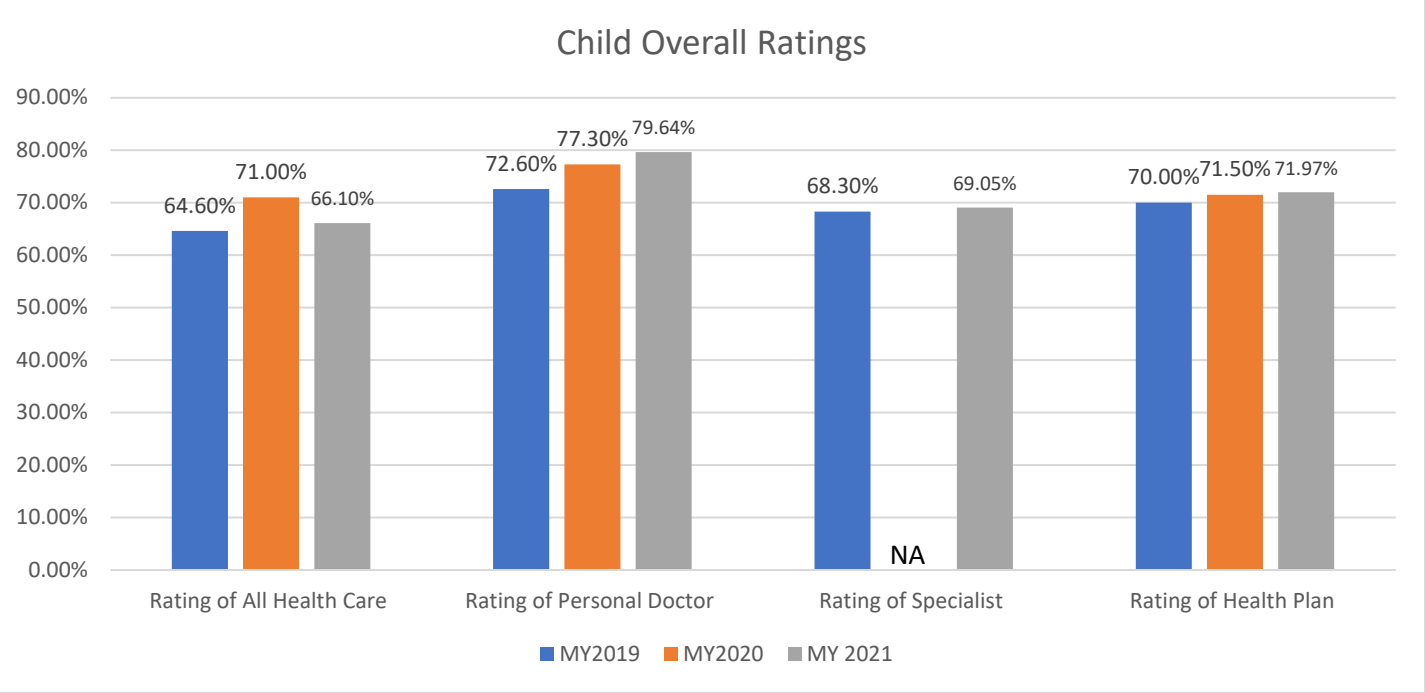
**Denotes performance below the 10th percentile.*



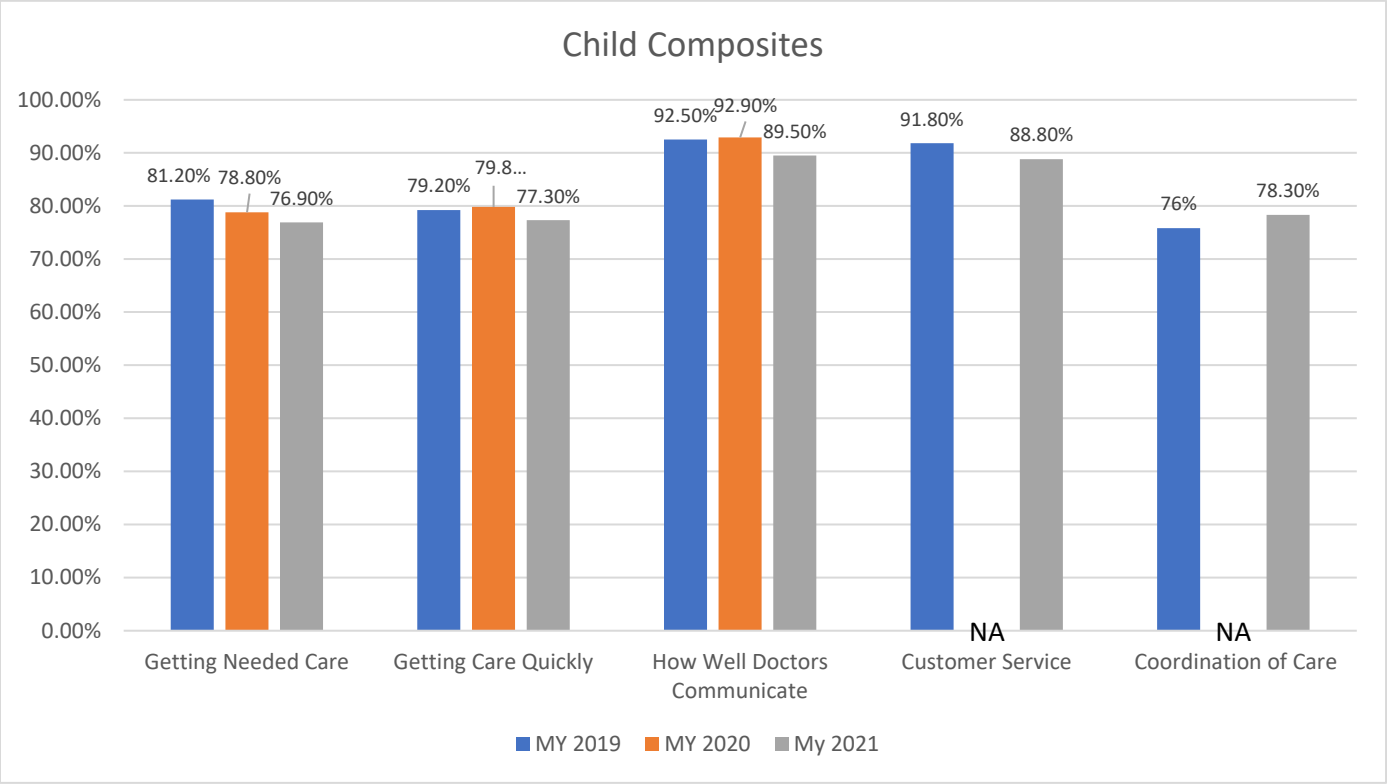
National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	80.88%	75.64	80.37	84.6	87.47
Getting Care Quickly	76.32%	70.19	77.9	83.82	86.85
How Well Doctors Communicate	89.3%	89.04	92.01	93.78	95.37
Customer Service	87.11%	84.05	87.86	90.7	92.34
Coordination of Care	79.7%	79.17	81.75	86.26	89.52

Medi-Cal Child CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	66.10%	65.35	68.39	73.19	77.06
Rating of Personal Doctor	79.64%	71.82	75.46	78.81	82.18
Rating of Specialist Seen Most Often	69.05%	68.22	70.34	74.07	80.36
Rating of Health Plan	71.97%	65.22	69.57	74.36	78.64

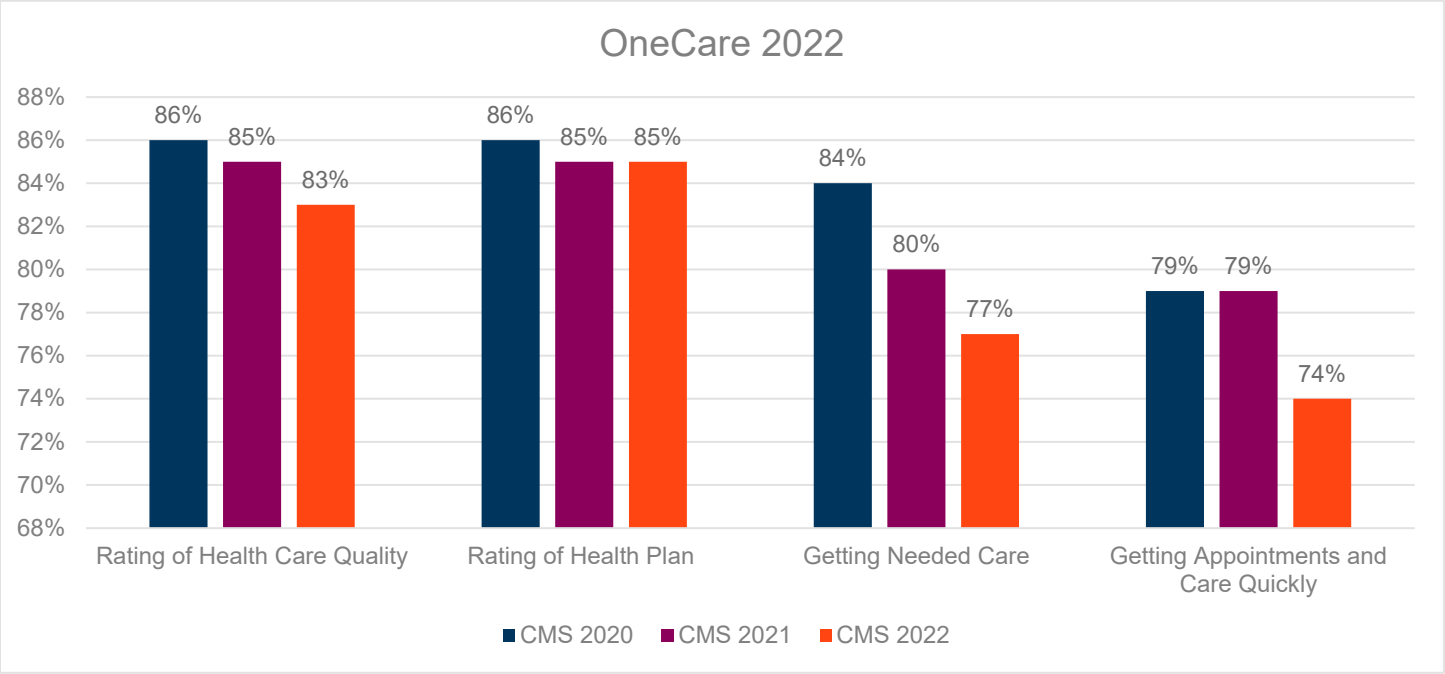


National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	76.9%	76.18	83.02	86.66	89.48
Getting Care Quickly	*77.3%	79.85	85.31	89.34	91.9
How Well Doctors Communicate	*89.5%	91.61	94.22	96.04	96.75
Customer Service	88.8%	84.83	86.79	89.32	91.67
Coordination of Care	*78.3%	78.81	83.2	86.73	90.12

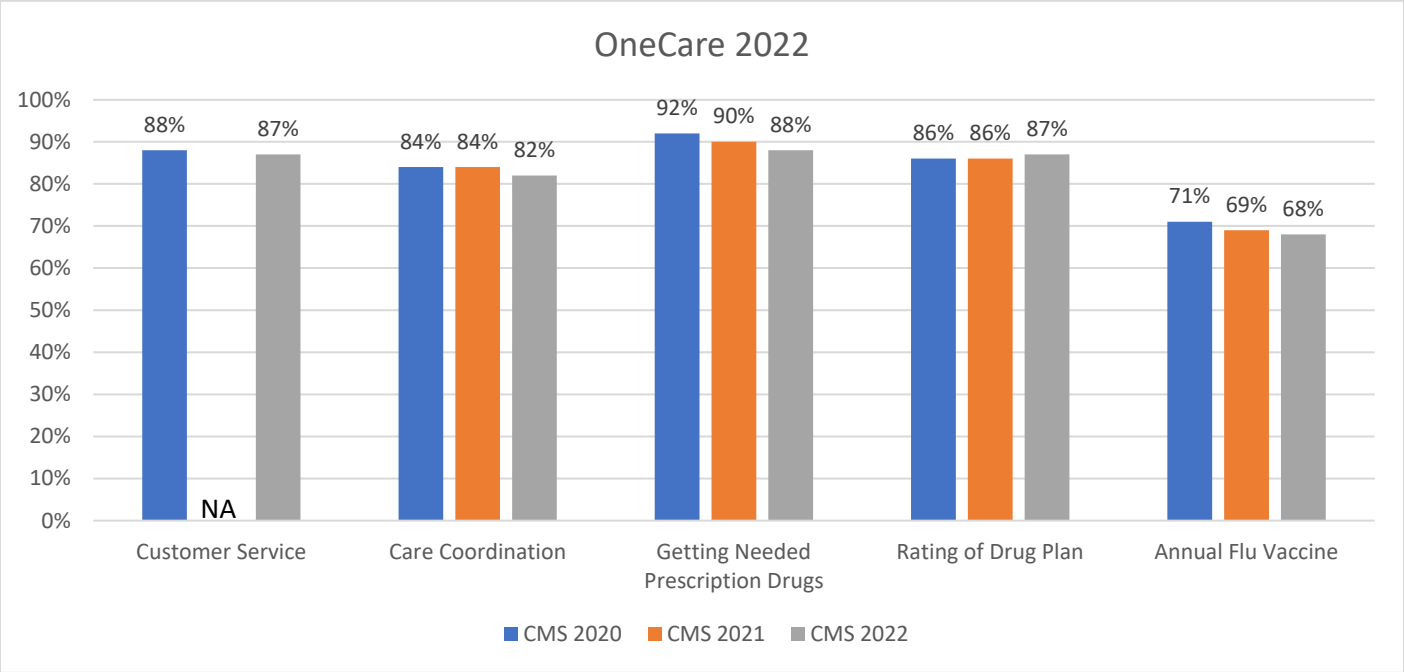
**Denotes performance below the 10th percentile.*

OneCare CAHPS Survey Results

Goal: To meet the CMS 3-Star Rating.



CAHPS Measure	Mean Score	Statistical Significance	Star Rating for 2022 CAHPS Score	Star Rating for 2021 CAHPS Score	Star Rating for 2020 CAHPS Score
Rating of Health Care Quality	83	Below Average	1	2	3
Rating of Health Plan	85	Below Average	2	2	3
Getting Needed Care	77	Below Average	1	2	4
Getting Appointment and Care Quickly	74	Below Average	2	3	4



CAHPS Measure	Mean Score	Statistical Significance	Star Rating for 2022 CAHPS Score	Star Rating for 2021 CAHPS Score	Star Rating for 2020 CAHPS Score
Customer Service	87	Below Average	1	N/A	2
Care Coordination	82	Below Average	1	2	2
Getting Needed Prescription Drugs	88	Below Average	2	2	4
Rating of Drug Plan	87	No Difference	4	3	4
Annual Flu Vaccine	68	Below Average	2	2	3

OneCare Connect CAHPS Survey Results

Goal: To meet the CMS National Medicare-Medicaid Plan (MMP) Average.

CAHPS Measure	CMS 2019 Results	CMS 2021 Results	CMS 2022 Results	CMS National MMP Results	Statistical Significance
Getting Needed Care	3.27	3.37	3.31 (-)	3.38	Below Average
Getting Appointment and Care Quickly	3.2	3.14	3.19 (-)	3.28	Below Average
Rating of Health Care Quality	8.2	8.6	8.6 (+)	8.5	No Difference
Rating of Health Plan	8.5	8.5	8.5 (-)	8.6	Below Average
Customer Service	3.58	3.62	3.59 (-)	3.68	Below Average
Care Coordination	3.47	3.52	3.53 (-)	3.55	Below Average
Getting Needed Prescription Drugs	3.57	3.65	3.63 (-)	3.68	Below Average
Rating of Drug Plan	8.3	8.5	8.5 (-)	8.7	Below Average

Case mix adjusted mean on a 1-4 scale. +/-=score increase/decrease from 2021.

a. Grievances:

   Analysis of grievances as they relate to member experience showed the following as a percentage of total grievances for CalOptima: Access 19%, Attitude and Service 62%, and Quality of Care 8%.

Analysis

a. CalOptima Health reviewed all MY 2021 CAHPS rates in detail and compared them with the benchmarks.

- Apart from one child measure at the 66th percentile (Rating of Personal Doctor), the remaining CAHPS measures remain below the 66th percentile for Medi-Cal.
- For OneCare, one measure, Rating of Drug Plan, received a CMS 4-Star rating with the remainder of the Star measures below a CMS 4-Star Rating.
- OneCare Connect measures were all considered “Below Average” except for “No Difference” for the measure of Health Care Quality.
- CalOptima Health did not meet the goals set for CAHPS apart from one OneCare CAHPS measure meeting a CMS 3-Star Rating and one Medi-Cal measure meeting the Quality Compass 66% benchmark. OneCare CAHPS performed “Below Average” for eight measures and OneCare Connect performed “Below Average” for seven measures. The “Below Average” for OneCare measures are Rating of Health Care Quality, Rating of Health Plan, Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, Getting Prescription Drugs and Annual Flu Vaccine. “Below Average” for OneCare Connect are Getting Needed Care, Getting Appointments and Care Quickly, Rating of Health Plan, Customer Service, Care Coordination, Getting Needed Prescription Drugs and Rating of Drug Plan. Medi-Cal performed below the 10th percentile for four measures. Those

measures are adult Rating of Specialist and child Getting Care Quickly, Care Coordination and How Well Doctors Communicate.

- There was improvement in OneCare's performance from a 3 to a 4 CMS star rating for Rating of Drug Plan.
- Response rates for CAHPS continue to decline for CalOptima's adult and child populations. The adult population response rate declined 4.01% and the child declined .47%. The OneCare response rate increased by 2.5% and the OneCare Connect response rate improved by 4.1%.

b. Member grievances related to member experience showed an increase in grievances by 7% for Access, a decrease of 2% for Attitude and Service and a decrease of 3% for Quality of Care.

Barriers

- Response rates continue to decline for CAHPS surveys.
- Appointment Timeliness and Availability: Members were unable to obtain timely appointments for routine and urgent care. Providers continue to offer telehealth services instead of in-person for the first initial visit. Many members prefer in-person appointments. The lack of extended office hours for urgent appointments and overcapacity of members for PCPs contributed to appointment access issues.
- Members experienced challenges with reaching providers for a variety of reasons, including provider not seeing new patients, provider cancelled appointment and phone calls not being answered.
- Referrals expired because patient could not get an appointment or provider canceled/changed appointment. During the pandemic, members did not go to providers for many routine care services during pandemic, resulting in doctor offices being behind on preventive screening services.

Opportunities for Improvement

- To improve response rates, CalOptima Health will further increase the survey oversample for those populations affected.
- CalOptima Health is in discussions with our contracted survey vendor to use a QR code that will allow the member to access their survey electronically for ease of use to improve response rates.
- CalOptima Health is exploring engaging with a predictive analytics vendor that would provide CalOptima Health with a defined path and process to improve CAHPS scores. Next steps are to bring vendors in for demonstration with potential for RFP.
- CalOptima Health to issue Corrective Action Plans (CAPs) to nine health networks with Medi-Cal Member Experience Health Network Quality Ratings below 2.5.
- Improve access to appointment availability and telephone accessibility by educating and outreaching to providers with challenges in providing care timely.
- CalOptima Health sent out 1,643,233 text messages from April to December 2021. All messages were COVID-19 related and informed members they were eligible for the vaccine and/or booster, promoted vaccine events, provided information homebound members on how to get the vaccine at home and promoted CalOptima Health's COVID-19 vaccine gift card incentive.

Member Experience (Behavioral Health Survey)

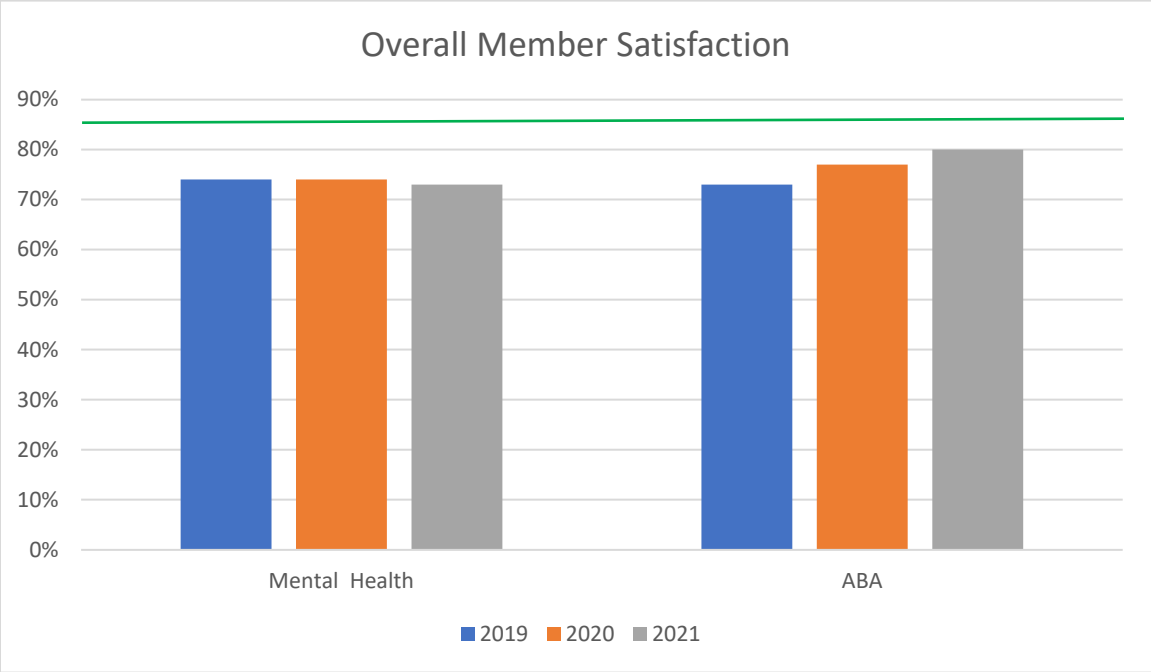
CalOptima Health conducts comprehensive behavioral health surveys and analyses annually to assess member satisfaction regarding behavioral health (BH) services. CalOptima Health worked with an outside vendor to field the 2022 Behavioral Health Member Experience Surveys to measure member satisfaction on BH services received in 2021. Two separate surveys were administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses for both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The consistent areas surveyed annually since managing BH services in house (i.e., non-delegated model) are Access to Services, Treatment Experience and As a Result of My Treatment. Additional questions on telehealth services, duration of treatment and overall experience were included based on feedback received from the Behavioral Health Quality Improvement (BHQI) Workgroup, Member Experience Committee and Quality Improvement Committee (QIC).

Interventions

a. A two-wave mailout survey methodology using a random sample size of 4,739 members to carry out the survey. Members of all ages and genders were surveyed. The survey was available to all members in their preferred language. Questions were scored on a five-point Likert scale that allowed the members to express how much they agree or disagree with a particular statement and included an option of Not Applicable (NA). The response rate for the MH services survey was 10% for a total of 406 completed surveys and 19% for a total of 89 completed surveys for ABA services.

b. CalOptima Health Behavioral Health Quality Team increased the sample size of members surveyed for the MH Services Survey from 1,572 in the prior year to 4,246 with the intent to capture a representative sample and receive more responses. Similarly, the ABA Services Survey sample size was also increased from 228 members in the prior year to 493 members.

Findings



Benchmark Goal = 85% Satisfaction Rate

Analysis

CalOptima Health has established an overall satisfaction goal of 85%. The Overall Member Experience Survey rates for areas surveyed consistently year-to-year (i.e., Access to Services, Treatment Experience and As a Result of My Treatment) did not meet the intended goal of 85%. The MH survey fell short at 73% with a 12 percentage point gap to goal in 2021. ABA received an 80% satisfaction rate but missed the goal by 5 percentage points.

Barriers

The CalOptima Health BHQI Workgroup identified potential barriers and reviewed them at the Member Experience Committee and QIC.

c. Process Perspective: Reviewed survey questions, length of survey, methodology (e.g., mail verses other mediums, best time to administer, etc.), and survey burnout/fatigue and member abrasion.

d. Quality Perspective: Access to services was an area that resulted in lower satisfaction rates. With the ongoing public health emergency for the COVID-19 pandemic initiated in March 2020, the impact was still being felt in 2021. During this time many provider offices were closed or made changes to their schedules. Appointments were hard to obtain, and members preferred not to go in person. In addition, the number of members accessing services increased.

Opportunities for Improvement

- Shortening the surveys in an attempt to increase response rate and address member abrasion.
- Fielding the surveys after the holidays.
- Improving access to services by increasing provider availability.

i. Increasing provider rates: the CalOptima Health Board of Directors approved rate increases for ABA and MH providers. The hope is that this will open up panels that have been closed and recruit new providers allowing more availability of providers for members.

ii. Increase Network: DHCS Children and Youth Behavioral Health Initiative (CYHBI) investments focused on increasing access through offering additional opportunities for mental health. For instance, the Student Behavioral Health Incentive Program (SBHIP) will allow youth to receive mental health services on or near a school campus. In addition, a new fee schedule will allow CalOptima Health to reimburse for such services in 2024.

Improving Access to Care

Improving Access: Annual Network Certification (ANC)

DHCS established network adequacy standards and assesses and certifies the adequacy of managed care plan's provider network at least annually through the ANC process.

1. Changes to Annual Network Certification in Draft APL Network Certification and Timely Access

a. DHCS to set an 80% minimum performance for Timely Access Standards.

b. Non-urgent follow-up appointments for non-physician mental health providers to change from 20 business days to 10 business days.

c. DHCS to provide a list of mandatory provider types for health plans to confirm whether the provider is contracted and in the network.

d. DHCS to run the time/distance analysis on behalf of the health plans using ArcGIS and a new set of population data points.

e. Health plans are not allowed to use telehealth to cover areas not meeting time/distance standards, if the telehealth ratio is met.

2. 2022 ANC Submission

a. CalOptima Health completed the ANC submission in Q4 2022, with the exception of the time/distance submission.

    i. Time/distance analysis to be provided to health plans by DHCS in December and health plans will have 30 days to submit.

b. CalOptima Health met requirements for Mandatory Provider Type.

c. CalOptima Health did not meet 113 areas (provider type/ZIP code combinations) for time/distance analysis.

    i. Currently awaiting DHCS detailed analysis. For each area of non-compliance, CalOptima Health will submit evidence of contracting or outreach efforts.

Subcontracted Network Certification (SNC)

For managed care plans with subcontracted delegates, DHCS expects plans to assess and certify the adequacy of the plan's provider network at least annually through the SNC process, beginning in 2023.

1. Changes to Subcontracted Network Certification

a. DHCS to stagger submissions for network certification and delayed the SNC submission until after the ANC submission.

b. DHCS plans to issue an SNC APL in Q1 2023. Submission likely to reflect ANC submission.

2. Actions to Prepare for ANC

a. CalOptima Health shares health network-specific SNC performance with each health network quarterly

    i. Report includes Mandatory Provider Types, Provider to Member Ratios, Time/Distance Analysis and Timely Access (annual data)

b. Health networks have implemented the following:

    i. Conducted data validations

    ii. Identified Out-of-Network providers to cover access gaps

    iii. Submitted PDSAs to address timely access

Improving Access: Appointment Availability and Telephone Access

CalOptima Health contracted with a health care survey vendor to field a telephone survey to our network providers to assess their compliance with CalOptima Health's Timely Access Standards to monitor telephone and appointment wait times. The survey used a combination of a "mystery shopper" methodology, in which the interviewer posed as a family member seeking the earliest appointment for a relative, and a "direct script" methodology, in which the callers identified themselves on calling on behalf of CalOptima Health in order to obtain appointment data. Callers then followed the script verbatim in order to collect the data. The direct script methodology was also used to collected administrative compliance data, for example, how long it takes to triage patients, and if providers are currently accepting new patients.

Three unique scripts were developed to collect appointments for several provider categories, including Primary Care, OB/GYN, Specialty Care, Non-Physician Behavioral Health Care, Psychiatric Care, and Ancillary Care across all programs Medi-Cal, OneCare and OneCare Connect.

The data pull methodology included both census and sampling data. Census data was used for provider types with universes with less than 100 providers. Sampling was used for provider types with universes of 100 and more and included a pull of a random sample to ensure a minimum of 30 completed surveys. For the 2021–22 survey, the total universe included 2,828 unique provider records, and a total of 3,828 contact records, which included providers with more than one location.

CalOptima Health established a MPL of 80% or better at the plan and health network level.

The most recent survey was fielded during business hours September 14, 2021, through July 1, 2022. Providers were not called on weekends or holidays and for each contact, the surveyor made three attempts maximum to reach a live person to participate in the survey. The surveyor collected first and second appointment availability, but data included in this evaluation represents availability for first appointment only.

Findings

The following tables represents Timely Access Survey results for the past three years, 2019 through 2021. The first table represents appointment availability results and the second represents administrative-telephone access. Telephone access was monitored for two years, from 2020 to 2021.

The goal was MPL of 80% or better at the plan and health network level.

Appointment Availability Results By Year (2020–21)

Appointment Types	*2019*	*2020*	*2021*	*Met MPL*	*Difference 2020-2021*
Primary Routine (10 business days)	67%	76.2%	69.2%	Not Met	-7
Primary Care Urgent (48 hours)	21%	68.4%	62.0%	Not Met	-6.4
Primary Care Physical Exam (30 calendar days)	81%	84.6%	75.8%	Not Met	-8.8
Ob/Gyn Prenatal (OC/OCC: 2 weeks; MC: 10 business days)	70%	80.4%	77.1%	Not Met	-3.3
Ob/Gyn Urgent (48 hours)	-	59%	74%	Not Met	+15
Specialist Routine (15 business days)	58%	67.7%	60.6%	Not Met	-7.1
Specialist Urgent (96 hours)	16%	56.1%	63.7%	Not Met	+7.6
Psychiatrist Routine (15 business days)	45%	78.4%	61.9%	Not Met	--16.5
Psychiatrist Urgent (48 hours)	-	42.9%*	34.4%	Not Met	-8.5
Psychiatrist Follow-up (30 calendar days)	100%*	91.4%	66.7%	Not Met	-24.7
Non-Physician Behavioral Health Routine (10 business days)	75%	76.7%	76.0%	Not Met	-0.7
Non-Physician Behavioral Health Urgent (48 hours)	-	49.2%	60.0%	Not Met	+10.8
Non-Physician Behavioral Health Follow-up (20 calendar days)	97%	85.1%	70.6%	Not Met	-14.5
Ancillary Routine (15 business days)	75%	91.4%	88.9%	Met	-2.5

*Survey methodology changed from 2019 to 2020 resulting in the data not being trendable. Therefore, 2019 data presented is for informational purposes only. – (Dash) indicates no data available * Indicates denominator is less than 10*

Administrative-Telephone Access Results By Year (2020–21)

Standards	*2020*	*2021*	*Met MPL*	*Difference*
Call back time within 24 hours (Mystery-routine)	80.0%*	50.0%*	Not Met	-30.0
Phone triage patients within 30 minutes	93.7%	95.3%	Met	+1.6
Flexibility in scheduling members with disabilities	95.4%	97.0%	Met	+1.6
Instructs caller to ER/911	31.6%	20.8%	Not Met	-10.8
Informs caller of return call time	34.3%	14.1%	Not Met	-20.2
Call back time within 30 minutes (Direct-urgent)	28.6%	20.6%	Not Met	-8.0
Live person answers within 30 seconds	69.6%	72.5%	Not Met	+2.9
Currently offering telehealth	82.1%	76.3%	N/A	-5.8
Currently accepting new patients	52.6%	84.7%	N/A	+32.1
Currently accept CalOptima Health patients	86.1%	86.7%	N/A	-0.6
Call hold time does not exceed 5 minutes	82.6%	86.3%	N/A	+3.7

N/A indicates standard is not a requirement and is for informational purposes only.

* *Indicates denominator is less than 10*

Analysis

Appointment Availability

A review of the 2021–22 timely access study results shows that appointment access is an area of concern. The data shows there are opportunities for improvement for both routine and urgent appointment types, for almost

all provider types. The largest fluctuation in rateswas noted in standards related to psychiatry and non-physician behavioral health.

a. For 2021 results for Routine Appointments, all provider types were below the 80% MPL except Ancillary.
b. For 2021 results for Urgent Appointments, all provider types were below the 80% MPL.
c. From 2019–21, both Primary Care and Specialist Urgent Appointments have experienced an increase in rates by at least 40 percentage points.

Overall, there is a noted increase in appointment availability from 2019 to 2020, with a decrease in 2021 most likely due to COVID-19 and the PHE.

Administrative – Telephone Compliance Measures

A review of the 2021–22 timely access study results shows that telephone access is another area of concern. Of the seven required standards, two measures, "Phone Triage within 30 Minutes" and "Offering Flexibility in Scheduling Members with Disabilities," met the 80% MPL.

In reviewing the data, compliance rates trended downward from 2020 to 2021 and one measure, "Call back time within 24 hours" experienced the largest decrease from 80% to 50%, but it is important to note that the denominator was less than 10.

Barriers

- Some PCPs have too many members in their panel making it difficult to get an appointment. There may be an adequate number of practitioners in CalOptima Health's network, but not all of the providers have open panels or are available to see new patients.
- There are not enough specialists in the network. In certain areas of South Orange County, CalOptima Health is currently contracted with a low number of specialists, with several not meeting the 80% MPL for both routine and urgent appointments: cardiology/interventional cardiology, endocrinology, gastroenterology, neurology, psychiatry and pulmonology.
- Specialty care appointments require referrals and authorizations. The overall process takes too long and is cumbersome.
- For both PCPs and specialists, CalOptima is a Medi-Cal plan and reimburses providers utilizing the Medi-Cal reimbursement rate structure, which is significantly lower than reimbursement rates for commercial contracts.
- The health care industry recently experienced a shortage in labor, especially with the onset of COVID-19.
- Due to COVID-19 and the PHE, more members may have stayed home and avoided going to provider offices. Now that restrictions have been lifted and COVID vaccines are in place, members are more comfortable going out and seeking appointments. This may have put unexpected strain on provider offices with so many members playing catch-up for the past two years and seeking access virtually at the same time.

Interventions

- Monitored PCPs panel capacity on a monthly basis. Issued quarterly notifications of closure for PCPs who have a panel of more than 2,000 CalOptima Health members to prevent members from being assigned to PCPs who do not have the capacity to provide appointments timely due to a large panel of members.

i. As of CY 2021, identified 54 PCPs nearing or over capacity, 44 panels closed and seven re-opened.

- Provider Relations focused on expanding the network through the Provider Data Validation project. Provider Relations focused on outreaching and reviewing submissions from providers on the validation forms to possibly re-open panels for those who were not overcapacity, which in turn expands the network for new patients. As of third quarter, Provider Relations has outreached to approximately 70% of the providers on the outreach list.
- Provider Relations outreached to providers who were nearing and overcapacity for closed panels, inquiring about additional providers, including mid-levels to add to credentialing process.
- Issued CAPs to health networks not meeting timely access standards to improve appointment availability and telephone access.
    i. In January 2022, CalOptima Health issued corrective action to 12 health networks for the following three areas in the form of Plan-Do-Study-Acts (PDSAs):
        a. Improve member access to PCPs
        b. Improve member access to specialists
        c. Telephone access
        d. Improve member access for Medi-Cal population.

    ii. Submission was received for all 36 PDSAs with the majority of the networks choosing to "Adopt," meaning implement the PDSA. Popular interventions include:
        a. Reopen the number of PCPs with closed panels.
        b. Reduce non-compliance on pre-recorded telephone message.
        c. Educate providers on telephone access.

- In 2020, CalOptima Health began issuing letters to providers who were identified as non-compliant with Timely Access standards. Letters clearly addressed areas not met, including recommended list of best practices and a copy of CalOptima Health's Timely Access standards. Letters are sent to providers via USPS mail, and providers' contracted health networks are notified as well. Once a provider is identified as non-compliant for a measure, they are monitored for up to an additional two years. There are a total of three different letters that can be issued to a provider for consecutive non-compliance.
    i. Education letter – Year 1: Letter is sent when provider is identified as non-compliant for a measure the first year.
    ii. Warning letter – Year 2: Letter is sent when a provider is identified as non-compliant for the same measure two consecutive years.
    iii. Escalation CAP letter – Year 3: Letter is sent when a provider is identified as non-compliant for the same measure for three consecutive years.
    iv. For the second year, letters were mailed to providers in Q4 2021. Education Letters (first-year notification) – 1,425 notices mailed. Warning Letters (second-year notification) – 123 notices mailed.
- Expanded current network by continued outreach and recruiting efforts to add new providers, with a focus on specialty types identified as not meeting MPL.
    i. In 2021, CalOptima Health successfully contracted with more than 234 PCPs and 460 specialists.

f. Provider Relations representatives met with provider offices to ensure provider directory validations were being returned. Provider Relations representatives and the director met with FQHCs to alert providers of the open/closed panel topic.

Opportunities for Improvement

- During the provider survey, CalOptima Health tracked call disposition for those calls that were not able to be completed for various reasons, e.g., wrong number, provider name not recognized, provider left practice etc. CalOptima Health will take this disposition information and use it as an opportunity for data cleanup and validation within our internal data systems. One project, in particular, will include updating the provider directory to ensure contact information is correct and members are able to access their providers.
- Based on the 2021–22 Timely Access results, issue new letters for non-compliance. This set of letters will include a CAP for providers who have been identified as non-compliant for the same standard for three consecutive years.
- For providers identified as being non-compliant for two consecutive years and who receive a letter for the second time, notify one of their contracted networks to conduct education on Timely Access standards.
- Survey providers to identify providers' biggest challenges/barriers in providing timely access to care.
- Develop a process for monitoring and escalating providers with a pattern of not being available to offer members to access care.

Improving Access: Mandatory Provider Types, Provider/Member Ratios, and Time/Distance

1. Overview

CalOptima Health routinely assesses the provider network for all programs including Medi-Cal, OneCare and OneCare Connect to ensure our members have appropriate access to care. This includes evaluating trends, determining if any gaps exist in a particular health network or with specific practitioner specialties, identifying opportunities for improvement, prioritizing those opportunities, and taking action to improve the network.

CalOptima Health established network adequacy in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services at both the plan and health network levels. Mandatory Provider Types (MPTs) standards apply only to the Medi-Cal program and Network Adequacy includes all three programs.

a. MPTs (Medi-Cal only) standards require CalOptima Health and contracted health networks to contract with at least one of the following MPTs for each contracted service area, where available: Federally Qualified Health Center (FQHC), Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNM) and Licensed Midwife (LM).
b. Provider network data is pulled quarterly to run an analysis for MPTs and Provider-to-Member Ratio (PMR) at the plan and health network level and compared to standards used to ensure members have the appropriate types of providers and an adequate number of practitioners in the network to access care. This analysis is used to determine whether CalOptima Health is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600 and MA.7007.
CalOptima uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet Time/Distance standards identified in CalOptima Health Access and Availability Policies: GG.1600 and MA.7007. The accessibility analyses must demonstrate coverage of the entire service area. CalOptima Health establishes network adequacy standards in accordance with state and federal regulations.

2. Findings

2022 Medi-Cal Mandatory Provider Types

2022								
	Q1		Q2		Q3		Q4	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
FQHC	25	Met	39	Met	39	Met	39	Met
CNM	3	Met	115	Met	111	Met	115	Met
LM	2	Met	4	Met	4	Met	4	Met

2022 Medi-Cal Provider-to-Member Ratios by Specialty Type

2022	**Medi-Cal Specialty**	**Q1**		**Q2**		**Q3**		**Q4**	
	Provider to Member Ratio	*Ratio*	*Met/ Not Met*	*Ratio*	*Met/ Not Met*	*Ratio*	*Met/ Not Met*	*Ratio*	*Met/ Not Met*
PCP	Family Medicine	1:444	Met	1:455	Met	1:475	Met	1:482	Met
PCP	Pediatrics	1:383	Met	1:385	Met	1:195	Met	1:190	Met
PCP	Internal Medicine	1:853	Met	1:863	Met	1:905	Met	1:942	Met
PCP	Total Primary Care Providers	1:170	Met	1:218	Met	1:228	Met	1:233	Met
Specialist	Cardiology/Interventional Cardiology	1:1,857	Met	1:1,629	Met	1:1,670	Met	1:1,693	Met
Specialist	Gastroenterology	1:2,320	Met	1:1,977	Met	1:2,004	Met	1:2,026	Met
Specialist	General Surgery	1:1,043	Met	1: 960	Met	1:199	Met	1:984	Met
Specialist	Hematology/Oncology	1:2,785	Met	1:3,408	Met	1:2,760	Met	1:2,786	Met
Specialist	Nephrology	1:3,392	Met	1:2,921	Met	1:3,028	Met	1:2,955	Met

Specialist	Neurology	1:2,561	Met	1:2,313	Met	1:2,325	Met	1:2,290	Met
Specialist	OB/GYN	1:426	Met	1:421	Met	1:217	Met	1:217	Met
Specialist	Ophthalmology	1:927	Met	1:1,859	Met	1:1,928	Met	1:1,882	Met
Specialist	Orthopedic Surgery	1:1,937	Met	1:1,855	Met	1:1,914	Met	1:1,940	Met
Specialist	Pulmonology	1:3,234	Met	1:2,922	Met	1:3,028	Met	1:3,009	Met

2022 OneCare Provider-to-Member Ratios by Specialty Type

2022	Specialty	Standard	Q1		Q2		Q3		Q4	
	Provider to Member Ratio	*Minimum # of Providers*	*# of Providers*	*Met/ Not Met*	*# of Providers*	*Met/ Not Met*	*# of Providers*	*Met/ Not Met*	*# of Providers*	*Met/ Not Met*
PCP	Primary Care	72	765	Met	748	Met	740	Met	733	Met
Specialist	Allergy and Immunology	3	24	Met	24	Met	24	Met	24	Met
Specialist	Cardiology	12	116	Met	116	Met	110	Met	108	Met
Specialist	Cardiothoracic Surgery	1	33	Met	32	Met	32	Met	31	Met
Specialist	Chiropractor	5	24	Met	24	Met	24	Met	24	Met
Specialist	Dermatology	7	58	Met	56	Met	57	Met	59	Met
Specialist	Endocrinology	2	44	Met	44	Met	45	Met	42	Met
Specialist	ENT/Otolaryngology	3	56	Met	55	Met	55	Met	54	Met
Specialist	Gastroenterology	6	85	Met	87	Met	82	Met	82	Met
Specialist	General Surgery	13	86	Met	86	Met	85	Met	85	Met
Specialist	Gynecology, OB/GYN	2	138	Met	132	Met	126	Met	126	Met
Specialist	Infectious Diseases	2	42	Met	43	Met	43	Met	43	Met
Specialist	Nephrology	4	73	Met	74	Met	76	Met	77	Met
Specialist	Neurology	6	97	Met	100	Met	98	Met	98	Met
Specialist	Neurosurgery	1	33	Met	33	Met	33	Met	33	Met
Specialist	Oncology - Medical, Surgical	9	101	Met	100	Met	99	Met	98	Met
Specialist	Oncology - Radiation/Radiation Oncology	3	27	Met	27	Met	26	Met	27	Met
Specialist	Ophthalmology	11	130	Met	128	Met	126	Met	122	Met
Specialist	Orthopedic Surgery	9	103	Met	102	Met	98	Met	97	Met
Specialist	Physiatry, Rehabilitative Medicine	2	23	Met	24	Met	24	Met	23	Met
Specialist	Plastic Surgery	1	25	Met	25	Met	25	Met	25	Met
Specialist	Podiatry	9	63	Met	62	Met	62	Met	61	Met
Specialist	Psychiatry	7	86	Met	84	Met	85	Met	83	Met
Specialist	Pulmonology	6	60	Met	61	Met	61	Met	61	Met
Specialist	Rheumatology	4	22	Met	22	Met	19	Met	19	Met
Specialist	Urology	6	49	Met	49	Met	50	Met	49	Met
Specialist	Vascular Surgery	1	21	Met	18	Met	18	Met	18	Met

2022 OneCare Connect Provider-to-Member Ratios by Specialty Type

2022 OCC	Specialty	Standard	Q1		Q2		Q3		Q4	
	Provider to Member Ratio	*Minimum # of Providers*	*# of Providers*	*Met/ Not Met*	*# of Providers*	*Met/ Not Met*	*# of Providers*	*Met/ Not Met*	*# of Providers*	*Met/ Not Met*
PCP	Primary Care	26	933	Met	921	Met	907	Met	900	Met
Specialist	Allergy and Immunology	1	28	Met	28	Met	28	Met	29	Met
Specialist	Cardiology	3	173	Met	172	Met	171	Met	171	Met
Specialist	Cardiothoracic Surgery	1	35	Met	35	Met	35	Met	34	Met
Specialist	Chiropractor	1	31	Met	30	Met	30	Met	30	Met
Specialist	Dermatology	1	91	Met	87	Met	86	Met	90	Met
Specialist	Endocrinology	1	64	Met	62	Met	64	Met	61	Met
Specialist	ENT/Otolaryngology	1	66	Met	66	Met	64	Met	61	Met
Specialist	Gastroenterology	2	116	Met	116	Met	115	Met	114	Met
Specialist	General Surgery	4	123	Met	123	Met	123	Met	125	Met
Specialist	Gynecology, OB/GYN	1	207	Met	206	Met	209	Met	209	Met
Specialist	Infectious Diseases	1	53	Met	53	Met	52	Met	53	Met
Specialist	Nephrology	2	96	Met	98	Met	95	Met	98	Met
Specialist	Neurology	2	125	Met	130	Met	128	Met	133	Met
Specialist	Neurosurgery	1	47	Met	47	Met	47	Met	46	Met
Specialist	Oncology - Medical, Surgical	2	149	Met	151	Met	151	Met	153	Met
Specialist	Oncology - Radiation/Radiation Oncology	1	40	Met	41	Met	43	Met	43	Met
Specialist	Ophthalmology	3	187	Met	184	Met	187	Met	185	Met
Specialist	Orthopedic Surgery	2	132	Met	131	Met	129	Met	128	Met
Specialist	Physiatry, Rehabilitative Medicine	2	38	Met	38	Met	39	Met	38	Met
Specialist	Plastic Surgery	1	34	Met	35	Met	34	Met	34	Met
Specialist	Podiatry	3	82	Met	81	Met	81	Met	82	Met
Specialist	Psychiatry	4	104	Met	101	Met	101	Met	99	Met
Specialist	Pulmonology	2	77	Met	77	Met	79	Met	83	Met
Specialist	Rheumatology	1	28	Met	29	Met	26	Met	26	Met
Specialist	Urology	1	59	Met	59	Met	60	Met	62	Met
Specialist	Vascular Surgery	1	35	Met	36	Met	34	Met	35	Met

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2022 Medi-Cal Time/Distance Analysis – Non-Compliance Count by ZIP Code

2022	Non-Compliance ZIP Code Count for Contracted Providers							
	Q1		Q2		Q3		Q4	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
Medi-Cal	0	Met	0	Met	0	Met	0	Met

2022 OneCare/OneCare Connect Time/Distance Analysis – Non-Compliance Count by ZIP Code

2022	Non-Compliance Zip Code Count for Contracted Providers															
	Q1 Specialties		Q1 Facilities		Q2 Specialties		Q2 Facilities		Q3 Specialties		Q3 Facilities		Q4 Specialties		Q4 Facilities	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/ Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
OneCare Connect	0	Met	0	Met	0	Met	1	Met	0	Met	1	Met	0	Met	1	Met
OneCare	0	Met	0	Met	0	Met	1	Not Met	0	Met	1	Not Met	0	Met	1	Not Met

Analysis

Mandatory Provider Types:

a. The 2022 results show MPTs were met monthly for all three MPTs at the plan level only.

b. In 2022, CalOptima Health monitored 13 health networks for MPTs. Fourth quarter findings show all health networks met for FQHC except Kaiser Permanente. Twelve did not meet for CNM and 10 did not meet for LM.

c. As of date, we have several health networks in the works to contract with both a CNM and LM utilizing the State's list CalOptima Health provided to them. Health networks are not required to meet the FBC MPT requirement at this time, since there are no active providers meeting this requirement in the service area.

Member Ratios

a. The Medi-Cal Provider-to-Member Ratios table shows all specialty types met theprovider-to-member ratios, and Pediatrics and OB/GYN showed improvement in the ratio by the end of 4th quarter. At the health network level, two networks, Arta Western (Ophthalmology) and Monarch (Orthopedic Surgery), consistently showed as non-compliant for the same specialty for all four quarters.

b. The OneCare Provider-to-Member Ratios plan level results show all specialty types met all four quarters in 2022. At the health network level, with the exception of Monarch, seven out of eight networks consistently showed as non-compliant for Chiropractor for all four quarters.

c. The OneCare Connect Provider-to-Member Ratios plan level results show all specialty types met all four quarters in 2022. At the health network level, AMVI consistently showed as non-compliant for the following specialties for all four quarters: Chiropractor, Neurosurgery, Psychiatry and Pulmonology.

Time/Distance:

d. In 2022, the Time/Distance tables show CalOptima Health was compliant at the plan level for all three programs (Medi-Cal, OneCare and OneCare Connect). Over 25 different specialties were monitored for each program, and all were at 100% compliance, at minimum for either Time or Distance.

   i. At the health network level, CCN is the only contracted health network (out of 12) to consistently meet the Time/Distance standards for Medi-Cal.

   ii. At the health network level, none of the 11 contracted networks met the Time/Distance specialist standards for OneCare Connect.

   iii. At the health network level, Monarch is the only network (out of eight) to consistently meet the Time/Distance specialist standards for OneCare.

b. Time/Distance is measured by facility type for OneCare and OneCare Connect programs. In 2022, most of the facility types were met by both programs, with the exception of Speech Therapy not meeting minimum performance for three quarters in OneCare.

Interventions

- CalOptima Health targeted reducing gaps within the provider network and improving upon Provider-to-Member ratios and Time/Distance performance.
- CalOptima Health actively recruited hard-to-access specialties for the CCN network in 2020 and 2021, with a focus on out-of-networks (General Surgery, Ophthalmology and Orthopedic Surgery).
- During the Provider Data Validation, CalOptima Health's Provider Relations department encouraged providers who have requested to close their panels for various reasons other than over-capacity, to consider re-opening to improve access.
- CalOptima Health worked with contracted health networks to certify for Sub-Contracted Network Adequacy (SNC) and issued Timely Access PDSAs.
- CalOptima Health provided health networks with Alternative Access Templates (AATs) to help health networks identify providers for each ZIP code identified as non-compliant using CCN's universe.
- Process Excellence led a provider onboarding end-to-end process that included a review of the provider recruiting process and workflow. In review of the OON data, it was determined that most of the requests were made by health networks and not CCN.
- CalOptima Health is working on developing a regular reporting tool to share with health networks on OON performance as part of the Subcontracted Network Certification Summary Quarterly report.
- Provide health networks with an updated copy of State's MPT lists at least annually.

Barriers

- Provider data is collected and housed across multiple databases at CalOptima Health and contracted networks. Counts may not be truly reflective of what is contracted within the network.

- Databases may have limitations and only be capable of holding information one specialty type per provider. This can potentially result in an undercounting of providers when a provider is credentialed in more than one specialty.
- CalOptima Health is a Medi-Cal plan and reimburses providers utilizing the Medi-Cal reimbursement rate structure. This rate is generally lower than commercial and non-medical rates, making it less appealing for providers and specialists to contract with CalOptima Health.
- CalOptima Health uses different software than the State to monitor Medi-Cal time/distance; therefore, it is challenging to tie back to State calculations to validate. A few health networks use programs like Google Maps, which is an additional challenge due to low accuracy.
- DHCS requirements for CNM and LM require specific licensure that is not common.
- MPT data source "274-File" does not reflect the required licensure type as listed in the APL, even if the practitioner has correct taxonomy code(s).

Opportunities for Improvement

- Continue targeted outreach to and recruitment of providers and specialists.
- Issue CAPs to both health networks and individual providers for access and availability.
- Invest in advanced software, e.g., ArcGIS to align with DHCS in Time/Distance analysis.
- Update the data source for "274-File" to reflect the correct licensure type or modify APL to reflect the correct licensure type as in the data source.
- Streamline the provider onboarding process for providers to increase the ease of entering into the CalOptima Health provider network.
- Develop an access scorecard or dashboard to better monitor our provider access performance.

Improving Patient Safety

Post-Acute Infection Prevention Quality Initiative (PIPQI)

PIPQI is a CalOptima Health quality initiative program aimed at reducing antibiotic-resistant bacteria in nursing homes. Participating nursing facilities utilize Chlorhexidine Gluconate (CHG) soap for all baths and showers and Iodophor nasal swabs 5 days per week every other week. The program ended on 6/30/2022.

Prior to the implementation of PIPQI, the University of California, Irvine (UCI) conducted a program called SHEILD following the same infection prevention principles.

Interventions

a. The PIPQI team uses one training video, created by the UCI SHEILD Team, to review with all participating nursing facilities monthly since March 2020.

b. Hospital-Acquired Infections (HAI) scores are submitted each month by the nursing facility staff members to the CalOptima Health PIPQI nurses. Using this data, the CalOptima Health nurses track and trend HAI events in each nursing facility and provide feedback to the facilities on their individual trends.

c. The PIPQI team collects invoices showing proof of product purchasing.

    i. In 2021, we began to look at the quantitative data in more detail to track trends from individual nursing facilities to assist them with ensuring they have adequate quantities available for their residents.

    ii. A data set was created in January 2021 that determined a product quantity for each facility based on the 75% of the licensed beds being filled.

iii. Once that was completed, we compared the amount projected for the facilities to the actual invoices given by the PIPQI staff.

d. The PIPQI team has updated all training materials and distributed them to the participating nursing facilities.

e. In person, hands-on training sessions provided the nursing facilities with a greater emphasis on the compliance of their staff and residents with following the PIPQI protocols.

Findings

a. The chart below shows the average HAI Score for all facilities throughout the course of 2022. Lower scores indicate fewer infections in the nursing homes, and the staff works with facilities to decrease or maintain their individual HAI scores.

Month	Average HAI Score for all 26 Facilities
January 2022	6.31%
February 2022	5.14%
March 2022	5.04 %
April 2022	4.61%
May 2022	3.83 %

b. As predicted, we see that as we transition from the winter months into the summer months, the HAI scores trend downward.

c. The CHG and Iodophor invoice data collected shows there are still ongoing gaps in product purchasing and the data being made accessible to CalOptima Health. The facilities continue to not submit the CHG and Iodophor invoices despite the in-person, telephonic and email reminders.

Analysis

a. The original financing for PIPQI ended in March 2022. A new request was granted by the CalOptima Health Board of Directors to continue the program another three months at a decreased reimbursement rate. The extension of the program beyond the original ask did not result in any improvements in the quality or quantity of the data being submitted by the nursing facilities, so the program concluded in June 2022.

b. In 2020–21, the average HAI scores for all months was 4.26% and in 2022 the average score was 4.98%.

Barriers

- Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.
- High turnover rates in facilities create a need for constant PIPQI training.

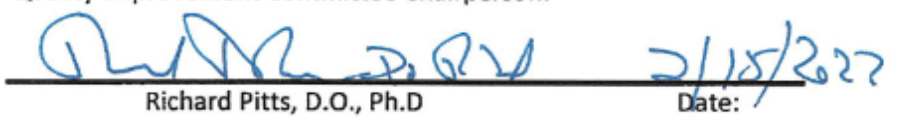
- Due to COVID-19, CalOptima Health nurses were not allowed to conduct on-site visits for monitoring or training of facility staff from March 2020 until March 2021.
- High staff turnover rate in the nursing facilities, including central supply and housekeeping employees, due to the effects of the pandemic
- The census in the nursing facilities have been fluctuating and there are times when they are at less than 75% capacity; however, this is a rare occurrence and only contributes to a small margin of data.
- Of the invoices submitted, there is only a small margin that is purchasing at or above the projected quantities. Since these quantities are based on each resident following the protocols as directed, (4oz. bath/shower every other day and 10 Iodophor Swabs/month) we are seeing facilities show compliance with or above average utilization of the products.

Opportunities for Improvement

a. The original financing for PIPQI ended in March 2022. A new request was granted by the CalOptima Health Board of Directors to continue the program another three months at a decreased reimbursement rate. The extension of the program beyond the original ask did not result in any improvements in the quality or quantity of the data being submitted by the nursing facilities, so the program concluded in June 2022.

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:



Richard Pitts, D.O., Ph.D Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

I. PROGRAM OVERSIGHT

A. 2022 QI Annual Oversight of Program and Work Plan
B. 2021 QI Program Evaluation
C. 2022 UM Program
D. 2021 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, OC P4V, Data Mining/Bridge efforts)
M. Improvement Projects (All LOB)PIPs
N. Improvement Projects (All LOB)QIPs
O. Improvement Projects (All LOB)CCIP's
P. PPME/QIPE: HRA's
Q. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
R. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
S. CalAIM
T. Health Equity
U. DHCS Comprehensive Quality Strategy
V. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).
B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
C. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
D. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam
C. Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot

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 and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA
B. Blood Lead Screening (BLS) (LSC)

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Expanding Network of Providers Accepting New Patients
C. Improve Access: Timely Access (Appointment Availability)
D. Improve Access: Telephone Access
E. Improving Access: Subcontracted Network Certification

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Post-Acute Infection Prevention Quality Incentive (PIPQI)
C. Orange County COVID Nursing Home Prevention Program.

2022 Quality Improvement Work Plan
(1Q)

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I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 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 April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina	QIC	MC,OC,OCC	X	Strategy is current. We will need to update to align with 2022 HP NCQA requirements and DHCS.	Meeting will be scheduled in 2Q2022 to update.	
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.	Quarterly Adoption of Report	Marsha Choo/Laura Guest	QIC	MC,OC,OCC	X	**I. FSR/PARS/NF/CBAS** Subject: Anticipated launch of new DHCS FSR/MRR tools and standards July 1, 2022. Point of Information: Anticipate CBAS in-person services to begin July 1, 2022. **II. Credentialing/Recredentialing** Subject: Identified in March 2022: Organizational Providers - OneCare Project. For CCN and BH, there were 57 group practices that were identified as not credentialed, although the individual practitioners were credentialed. **III. PQI** Subject: Since cases are being reviewed while a grievance, the % of cases leveled as QOC has increased from 4-7% prior to 2021 to now at 21%. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.	**I. FSR/PARS/NF/CBAS** Actions: A. Working with PR, HNR and communications to send educational materials and tools for provider office B. Training providers and their staff, and the FSR Nurses C. Implementing changes to on-line tool data collection D. MRR tool preventive section has doubled for both peds and adult Concern: May lead to an increase in: 1)failed FSR and/or MRR audits, and 2)FSR/MRR CAPs issued **II. Credentialing/Recredentialing** Actions: A. As of May 31, 37 were processed for credentialing, including 5 PCPs. B. 14 OPs were identified for termination for various reasons. **Concerns:** A. Several OPs are missing required documentation for credentialing, which may lead to termination; B. May result in a drop in network adequacy for some specialties and/or PCP by geographic region. **III. PQI** Action: Continue with QOC grievance review by RN and MD Concern: Volume of PQIs are climbing again from 42 in December to 100 in May Action:Fair Hearings Commencing in Q2 **Concerns**: Results of Fair Hearing will be reported to QIC in Q3 and terminations may affect several networks. 1. PM- Provider termination will only affect the CCN network. 2. PCP - HPN/Regal, CCN, Optum-Arta, Optum-Talbert, Prospect and UCMG will all be affected by potential termination. HNs will be notified if Fair Hearing results in termination.	

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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	Tyronda Moses	QIC	MC,OC,OCC	X	On March 8th 2022, GARS Committee presented to QIC 4Q Member and Provider Complaint results. **- Medi-Cal Complaints:** 9% increase in total complaints; 7% decrease in member appeals; 5% increase in member grievances; 25% increase in provider appeals **- Medi-Cal Grievances by Category:** QOS continues to be the highest Grievance category. QOS increased by 11% from Q3 to Q4. CCN and Veyo continue to have the highest number of QOS grievances. **-- Other Increases:** Quality of Care increased by 32% (from 206 in Q3 to 272 in Q4). AltaMed, Monarch, CCN, COD had the most noticeable increase in QOC grievances. **-- Decreases:** Billing decreased by 2%; Access decreased by 17% (from 731 in Q3 to 609 in Q4); Appointment Availability (177 grievances); Telephone Accessibility (122 grievances) Specialty Care (101 grievances); Practitioner office site decreased 33% (from 9 in Q3 to 6 in Q4) **- Medi-Cal BH Grievances**: 28% decrease in BH grievances; Access decreased by 27%; QOS decreased by 32%; QOC decreased by 30%; Billing decreased by 6% **- OCC Complaints:** 10% decrease in total complaints; 32% decrease in appeals; 13% decrease in grievances; 22% increase in provider appeals **- OCC BH Grievances**: BH grievances increased by 4 in Q3 to 9 in Q4. **- OC Complaints:** 25% decrease in total complaints; Member appeals remained the same from Q3 to Q4; 12% decrease in member grievances; 59% decrease in provider appeals	Grievance trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are shared with a Provider Action workgroup for recommended action or escalation to the Member Experience Committee. Next GARS Committee is scheduled for QIC on June 14th.	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 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	QIC	MC,OC,OCC	X	In Q1, MemX Committee has reviewed/discussed the following: **2/9/22:** •Updates -Q4 workplan updates due 2/11 •Charter Review •DHCS Audit Findings •UM Dept Update •2022 Workplan Review •HN Improvement Plan	In Q2 MEMX Committee has one meeting scheduled, April 5.	
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	Utilization Management/ QIC	MC,OC,OCC	X	UMC reported to QIC on 2/15/2022. Presented 2021 3rd Quarter and Annual Trends (11/18/2021), - 3Q 2021 Operational Performance (MC,OC,OCC) Medical Auth 3 HN below goal for Urgent TAT, 1 for routine TAT - 3Q 2021 Utilization Outcomes (MC, OCC) Medical Measures met Goals, OCC measure Beddays and Readmissions did not meet goals - 3Q 2021 Operational Performance WCM goals are to TBD. - Prior Authorization (PA) Backlog update (Person: Leadership accountability and oversight, UM role vacancies, Process: Workflows lacked efficiency and visibility Lack of prioritization and planning System/Technology Clinical platform upgrade and ongoing maintenance, Staff readiness for platform upgrade) - Over/Under Utilization Monitoring, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM Update, BHI. - QIC accepted and filed meeting minutes from UMC Meeting (8/26/21).QIC Accepted and filed all documents.	UMC is scheduled to present Quarterly update to QIC on 4/12/2022. Along with DRAFTs of 2022 UM Program, 2021 UM Evaluation and List of Board Certified Consultants (AMR/MRIpA/Internal.)	

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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	QIC	MC	X	WCM CAC met on February 15, 2022 and approved the November 16, 2021 meeting minutes. Committee annual Conflict of Interest and Attestation forms were completed by all attendees. An update on the CalAim program was presented by Case Management Director, Sloane Petrillo. An update on Magellan Rx backlog issues of prior authorizations was shared with the Committee. CalOptima with collaboration of CHOC and UCI held meetings with Magellan in response to the issue. Magellan has hired additional staff and many prior authorization requirements were removed and the backlog issue has been caught up. Committee has concerns of a back log issue recurring when the prior auths are lifted in May. Will present an update at the next WCM CAC. Standing agenda updates for WCM Measures, GARS, and WCM Customer Service Inquires were presented. DHCS notice updates of CCS Medical Therapy Program Step 3b Guidance Related to Return to In-Person Services and DCHS Numbered Letter 03-0421 related to CCS program were also shared.	Next meeting scheduled for May 17, 2022 with an update to the Magellan RX backlog issue to be reported along with the standing recurring agenda items.	
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	Sandeep Mital	QIC	OCC	X	Preliminary analysis of MY2021 performance on the measures indicates that CalOptima has passed 7 of the 10 measures, which would make us eligible to receive 75% of the OneCare Connect Quality Withhold dollars back.	We will receive final confirmation of MY2021 performance from CMS in 2023 and then calculate and distribute health network withheld dollars.	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, **OC P4V,** Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. **[NEW] Development of the OC P4V program for MY2023**	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital	QIC	MC,OC,OCC	X	HEDIS MY2021 results achieved MPL for all DHCS selected measures except the newly added well child visits (W30) measure.	We are continuing to monitor performance in 2022 on a monthly basis. Next update to QIC will be in Sept .	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Successfully met all required criteria for Module 3. Began testing intervention. Mobile Mammography Event Q1: Completed 12 BCS for KCS CCN members. 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members. Module 1-3 Submitted and approved. Began testing intervention.	1) Continue testing intevention through the end of the PIP December 31, 2022. Scheduled KCS Mobile Mammogrophy Events for for 5/17, 8/15, and 10/24. 2) Continue testing intervention through the end of the PIP December 31, 2022. New target list for 2022 denominator provided to office (April).	
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs **MC QIP:** 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/**Helen Syn**	QIC	MC,OC,OCC	X	**MC QIP** 1) COVID QI Phase 2- a. SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS- Cycle 1: 3 provider offices conducted member outreach with combined CCS denominator of 4,235 and target outreach popuation of 2,172. The combined outreach rate at the end of cycle 1 was 53.22 % (1156/2172). Provider office staff received predetermined incentive based on the count of the target outreach list if 90% of members identified on target list were outreached. c. CIS Combo 10- Cycle 1 (10/14/21-12/31/21): Provide Office outreached and reconciled 100% of their target list of 663 members. Based on 2021 Annual Prospective Rate Report, provider office CIS-10 rate met the 66th percentile. Rate =44.24% (292/660). Cycle 2 (01/01/22- 03/31/22): data collection (claims/encounters) period to establish provider office rate for MY 2022 to pull new target list for office. 2) Q1 2022 results pending, reliant on Q2 2022 Statin Pharmacy data (slated for mid/late May 2022) to obtain results.	a1) Continue tracking members in need of diabetes screening test. a2) Continue prescribing provider outreach. b. CCS- For cycle 2 Provider Offices staff will still focus on outreaching to members to schedule cervical cancer screening but CalOptima plans to add a provider office staff tiered staff incentive that focuses on the number of completed cervical cancer screenings by June 2022. c. CIS Combo 10- Cycle 3 (04/18/22-06/30/22) Provider office received new target list of 677 members. Intervention includes, reconciling their target list, outreaching to members who are noncompliant, scheduling appointments and confirming if appointments were kept.	

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Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on **All LOB CCIPs** 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	ALL LOB CCIPs 1) Emerging Risk Health Coach Outreach OC CCIP 3 members, 1 Assigned, 1 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 46 members, 27 Assigned, 1 Unable to Contact, 3 No Longer Emerging Risk, 7 No Longer Eligible. 2) Q1 2022 results pending, reliant on Q2 2022 Statin Pharmacy data (slated for mid/late May 2022) to obtain results	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman/D. Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs **1) PME (OC):** a) HRA's Initial: Jan 100% outreach completed; Feb results after 4/30 and Mar results after 5/31/22. Annual: Jan, Feb, and March with 100% outreach completed. b) HN MOC Oversight(Review of MOC ICP/ICT bundles) 100% of bundles returned were reviewed in 10 business day TAT for both Jan and Feb. March is pending. **2) QIPE (OCC):** a) HRA's Initial: Jan 99% outreach completed; Feb and Mar 100% outreach completed. Annual: Jan, Feb, and March at 99% outreach completed. b) ICP High/Low Risk CA MMP 1.5 goal is 75%: High risk 85% and Low Risk 78% for Q1 2022 c) CA MMP 1.6 Care Goal Discussion: Q1 2022 is 98% for both initial and revised ICP. d) ICP Completed within 90 days MMP 3.2: Q1 2022 is 85% e) HN MOC 100% of bundles returned in January were reviewed in 10 business day TAT; February 96% were reviewed within 10 business days. March data is pending. **3) LTSS HRA OCC:** Monitor for timeliness on outreach for completion. Quarterly monitoring.	**1)PME (OC):** a) HRA's Continue same process. b) HN MOC Oversight(Review of MOC ICP/ICT bundles) Continue same process. **2) QIPE (OCC)**: a) HRA's Continue same process. b) ICP High/Low Risk CA MMP 1.5 goal is 75%: Continue same process. c) CA MMP 1.6 Care Goal Discussion: Continue same process. d) ICP Completed within 90 days MMP 3.2: Continue same process. e) HN MOC Continue same process **3) LTSS HRA OCC:** Ongoing Process.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson	QIC	MC	X	BHIIP: 5 provider groups submitted Q4 milestone reports, overall 97% of the targeted milestones were completed and reported to DHCS by 3/1/22. One provider group reported challenges completing milestones for Q3 & Q4 of 2021, and Q1 2022 and performance measures. The group selected new performance measures from an approved list provided by DHCS; MOU amended to reflect changes. A corrective action plan (CAP) was issued to address uncompleted milestones. CAP returned by 3/1 and reviewed by BHI and additional information requested. ABA P4V: Downloaded stats from Tableau to prepare the last ABA P4V report card for 2021. Requested Provider Relations to email the report cards to the providers by 2/2. Several discussions/meetings with medical director, sr reporting analyst, and P4V team to finalize the calculation methodology for the measurement year 2021 incentive payments.	BHIIP Q1 activities: 1) Prepare PY2 Q1 2022 milestone report for distribution in May to DHCS; 2) Review provider group's revisions to CAP and finalize; and 3) Prepare Q2 2021 incentive payment once received from DHCS expected in April. ABA P4V: 1) Prepare check request for the incentive payout by 3/31. 2) Discuss with ITS for report cards to be distributed bi-annually using the portal.	
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 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Katie Balderas/S. Hickman	QIC	MC,OC,OCC	X	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19: Outreaches are virtual and telephonic to three shelters: Yale Navigation Center, Costa Mesa Shelter, and Huntington Beach Navigation Center. In contact with recuperative care facilities telephonically to coordinate care with members. 2)Primary point of contact for coordinating care with collaborating partners and HNs: Through the Homeless Respons Team phone line. 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19. Clinical Field Team has worked with clinics to support outreach services to encampments. 4) Clinical Field Teams had 109 dispatches with a total of 94 individuals treated in Q1 2022. We added two additional referral sources for the CFT program in Q1 Be well Mobile Crisis Unit and Huntington Beach Police Mobile Unit.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19: Continue to look for additional opportunities for virtual and telephonic outreach to other shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs: Script will be implemented in Q2 to better track contacts. 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19. Continue to work with the county and other external partners to support their efforts at encampments. 4) CalOptima will continue to explore additional referral sources for the CFT program.	

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CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Sherry Hickman/**Gail McMillen**	QIC	MC	X	1) HHP transition members outreach completed. 2)WPC transition members outreach nearly complete. POF member outreach has begun and between these three groups 660 members have had outreach and 183 enrolled. 3)DHCS reporting Creation and implementation of weekly ECM activity log with validation process for health networks. Internal submission expected on 5/6 for one time and quarterly implementation. 4) Oversight Strategey for CalAIM-Undetermined at this time. First of two round review completed.	1) HHP transition members ongoing management of enrolled ECM members. 2)WPC transition members ongoing management of enrolled ECM members. 3)DHCS reporting Ongoing monitoring of weekly ECM activity log to support reporting metrics. 4)Oversight Strategy for Cal-Aim: Once 2nd round of reviews completed, a decision on frequency of monitoring. 5) working POF list for outreach to potentially eligible members.	
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	Katie Balderas/Marsha Choo	QIC	MC, OC, OCC	x	CalOptima issued an RFP in search of an NCQA consultant for both Health Plan Accreditation (HPA) as well as for Health Equity Accreditation (HEA). Standards for both HPA and HEA have been purchased. CalOptima launched a Health Equity Workgroup, developed a shared definition of Health Equity, and began developing a roadmap for advancing health equity that includes: 1) Making an explicit commitment to advancing health equity to internal and external stakeholders 2) Identifying existing and needed organizational assets, resources and leadership 3) Measuring health inequities and identifying impactful strategies focused on social determinants of health 4) Implementing short- and long-term strategies focused at the member, organizational and community level 5) Ongoing data collection, shared lessons and expanded capacity	NQCA consultant to be contracted and launch kick-off for both HPA and HEA. Next steps in the development of the Health Equity Framework include refining the overarching goals and creating more specific objectives.	
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo/Katie Balderas/Kelly Rex-Kimmett	QIC	MC, OC, OCC		CalOptima Quality reviewed a draft of the 2022 DHCS Quality Strategy and provided feedback. DHCS' final draft has been submitted to CMS.	Educate other areas on the elements of the 2022 DHCS Quality Strategy and focus on incorporating and aligning these elements with our QI Workplan.	
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	**[NEW} to 2022 QI Work Plan** SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	12/31/2022	Natalie Zavala	QIC	MC		1) Met DHCS deadlines: submitted Letter of Intent (LOI) to participate in SBHIP in January; submitted SBHIP Partner form in March. 2) Provided update at Special Joint MAC and PAC Meeting on March 10th. 3) Continued weekly internal meetings with Core Team. 4) Continued bi-weekly collaboration meetings with Orange County Department of Education (OCDE).	1) Meet with school districts on April 19th to review expectations and begin assessment phase of program. 2) Hold stakeholder workgroup in May. 3) Provide SBHIP update at WCM CAC 5/17.	

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II. QUALITY OF CLINICAL CARE- Adult Wellnes										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 3/31/22: BCS: 81 for MC and 2 for OCC; CCS: 149 for MC; COL: 1 for OC 1b. Transition to Member Health Reward Vendor Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2. Pending complete transition to member health reward vendor to define and set deadlines to implement. 3. Member Engagement Strategy:Texting: CCS texting campaign total= 11,512 IVR: CCS Total 2,800= 2,239 Message Left + 561 Message played; COL Total 512= 344 Message Left + 168 Message played; Social Media: CCS Static Social Media Post; COL Static Social Media Post Digital Ad: CCS digital ad; COL digital ad; Direct Mailing: 67,079 CCS MC member mailing; 17,069 BCS MC member mailing Community Connections: CCS article 4. Community Events: Mobile Mammography: KCS event 12 CCN members completed 5. 2022 February Prospective Rates (PR): Breast Cancer Screening MC: 44.42%, OC: 52.57%, OCC: 50.41% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 43.77% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 35.6%, OCC: 38.53% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Complete transition to member health reward vendor is set to be executed by August 2022. 2. Targeted member engagment and outreach campaigns to identified zip codes. 3. **Member Engagement** Texting: BCS texting campaign scheduled in May IVR: BCS scheduled for Q3/Q4 Social Media: BCS scheduled for Q3/Q4 Digital Ad: BCS scheduled Print Ad: COL scheduled Q2, BCS scheduled Direct Mailing: COL scheduled for Q2; CCS, BCS, COL scheduled for Q4 Community Connections: Article scheduled for Q2/Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue Live Call Campaign: Pending new contract 4. Community Connections: Ongoing mobile mamography events	
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1. COVID texting campaigns continued in Q4 2. COVID community vaccine events were held in partnership with OCHCA ongoing. 3. Vendor has processed a total of 604,521 incentives (cumulative) •PHM has processed a total of 133,572 incentives (cumulative). This total includes incentives processed in-house & through vaccine events. •Vaccine Events: □January 15th: 346 □January 22nd: 165 □February 19th: 170 □March 12th: 71 □March 19th: 85 □March 26th: 37 □Total vaccine events: 874 □As a reminder, the breakdown of the vaccine event totals may be different to the numbers reported by Community Relations. Community Relations totals represent all CalOptima members vaccinated and PHM numbers represent all that were handed a gift card. 4. VIP reimbursement data set provided to DHCS for First Submission. 5. VRP responses to DHCS coordinated by COVID Vaccination Workgroup	Texting campaigns continue. New texting messages will be updated to include expanded age ranges and booster shot eligibility. Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing. COVID vaccine events with OCHCA continue Future Vaccine Events: April 9th: 67, April 16th: 54, April 23rd: 42, May 17th , June 7th	
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q1 (February): 30 day- 16.67%, 7 day- 16.67%; BHI real-time report Jan-March: 30 day- 44%, 7 day- 29%. 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Difficulties included: members not attending follow-up appointments due to readmission; member declining assistance; and inability reaching members due to invalid phone numbers. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	

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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.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q1 (February): Initiation Phase- 41.04%, Continuation and Maintenance Phase- 59.57% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member f/u visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Created and submitted tip sheet on Treatment for Children with ADHD to communications for CalOptima Member Spring Newsletter.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Update data collection for compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters.	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	**[NEW} to 2022 QI Work Plan** 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q1 (February): M/C: 20.73%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Difficulties: attaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing.	1) Continue tracking members in need of diabetes screening test. 2) Continue prescribing provider outreach.	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	**[NEW] to 2022 QI Work Plan** 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q1 (February): 30 day- 24.94%, 7 day-16.12% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance.	1) Develop report on member ED visits to identify trends. 2) Attend at least 1 HN Quality meeting to discuss/ address barriers.	
IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 13 Processed, 9 approved, 4 denied 1b) Transition to Member Health Reward vendor. Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2) Diabetes A1C member mailers MC 7,803, OC 84, OCC 637 = 8,524 mailers Emerging Risk Health Coach Outreach: MC 185 Assigned, 3 No Longer Eligible, 4 No Longer Emerging Risk, 1 Opt Out, 3 Unable to Contact OC 3 members, 1 Assigned, 1 No Longer Eligible. OCC 46 members, 27 Assigned, 1 Unable to Contact, 3 No Longer Emerging Risk, 7 No Longer Eligible. 3) Member Engagegment Strategy: Texting: CDC texting campaign content submitted to DHCS for approval, currently under review. IVR: Campaign content completed and approved, pending launch date. Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 February Prospective Rates (PR): There were no A1C Testing rates for Feb 2022 PR A1C Adequate Control <8.0 MC: 1.99%, OC: 1.82%, OCC: 2.81% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). A1C Poor Control >9 MC: 97.98 %, OC: 98.00%, OCC: 96.81% Measure is performing better for all LOBs than same time last year (lower rate is positive trend) and below the 50th percentile (MPL).	1) Track and monitor until the end of member incentive year. Complete transition to member health reward vendor is set to be executed by August 2022. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: Pending DHCS approval launch date slated for Q4 2022. IVR: Approximate launch date slated for end of June 2022. Social Media: Campaign slated to launch Q3-Q4 2022.	

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Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 5 Processed, 5 approved, 0 denied 1b) Transition to Member Health Reward vendor. Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2) Diabetes Eye Exam member mailers MC 7,803, OC 84, OCC 637 = 8,524 mailers 3) Member Engagegment Strategy: Texting: CDC texting campaign content submitted to DHCS for approval, currently under review. IVR: Campaign content completed and approved, pending launch date. Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 February Prospective Rates (PR): Diabetes Eye Exams MC: 26.65%, OC: 35.45%, OCC: 35.32% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year.Complete transition to member health reward vendor is set to be executed by August 2022. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: Pending DHCS approval launch date slated for Q4 2022. IVR: Approximate launch date slated for end of June 2022. Social Media: Campaign slated to launch Q3-Q4 2022. 6) Submitted ticket to IS on 3/31/2022. Slated for completion Q2 2022.	
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	12/31/2024	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson	QIC		X	Planned activities being revisted for revised proposal and will pend approval by CMO/BOD	Planned activities being revisted for revised proposal and will pend approval by CMO/BOD	
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	QIC	MC	X	1) Member Health Reward for Postpartum care has been agreed by the business owners to not transition to the Health Reward Vendor due to the small volume and complexity of processing. 2) Process for the first quality Initiative mailing is being finalized. First mailing is projected to go out in Q2 2022. Mailing will target members that recently delivered and encourage timely postpartum care. Prenatal care article included in the Spring 2022 Medi-Cal newsletter, healthcare chat video on prenatal visits on immunizations on social media platforms, and social media posts related to prenatal/postpartum care. 3) Provider communication on Postpartum Care Extension. 4) Bright Steps Program conducted initial outreach to 1793 unique members. 1034 outreach attempts made to 623 for postpartum members, 238 postpartum assessments completed. 5) Total # of PPC health rewards approved for Q1: 63. 6) Planning for Diaper Day events in collaboration with CalFresh and community partners is continuing. Tentative schedule is being created for community events to take place in Q2 2022. 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. February 2022 Prospective Rates: Timeliness of Prenatal Care: 80.49% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 53.16%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin Q2 2022. 2) Prenatal and postpartum social media campaign is projected for Q2 2022. 3) Diaper Day + CalFresh community events to promote Bright Steps. 4) Medi-Cal newsletter article on postpartum care articled in Medi-Cal summer newsletter. 5) Postpartum Care Extension newsletter article in Medi-Cal summer newsletter.	

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VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Targeted member engagement and outreach campaigns in coordination with health network partner	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2 Newsletter, Well-Child Visits Flyer and Lead Poisoning Fact Sheet mailing slated for April 2022 - Targeted ad campaign for Well-Care Pediatrics and Immunizations via digital and social media - April World Immunization Week observance on social media - Community Connections April Newsletter for World Immunization Week observance - Medi-Cal member newsletter article on adolescent immunizations - Live call campaign for mi-year push for well-child and immunization measures. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics - Attend community events targeting the pediatric and adolescent population. - Plan back-to-school vaccination events. 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in January 2022 to health networks with Q4 2021 data on members that have not been screen as recommended for blood lead screening. Worked with ITS to leverage new provider portal and share blood lead screening report with CCN providers. Report to CCN is on track for Q2 2022. Beginning the implementation process for a health network attestation to ensure that HNs are sharing member detail blood lead reports with their providers. 2) Member education efforts: blood lead screening campaign on social media in March 2022, blood lead article in Medi-Cal newsletter in Spring 2022. 3) Prop 56 provider value based payments for Blood Lead Screening. February 2022 Prospective Rates Lead Screening in Children (in 2022 became an MCAS measure that will have to meet MPL). MC: 49.25% Measure is performing lower than the same time last year and has not met the 50th percentile (MPL).	1) Provider communication on blood lead screening testing and management through communication platforms, including Health Network Qualify Forum. 2) Blood Lead Screening report sharing to CCN Providers.	
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	MC,OC,OCC	X	The function of recruiting providers transitioned from Provider Relations to Contracting Department. In addition, the staff identified for recruiting providers has been on FMLA.	CalOptima is currently engaged in a provider onboarding end-to-end process led by Process Excellence that includes a review of the provider recruiting process and workflow.	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC		In Q1, the Provider Directory Validation Template was being revised and a new format has now been implemented which PR began using in Q2.	Provider Relations is now requesting PCPs and SCPs open panels during Provider Data Validation on a quarterly basis.	
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) No update for Q1 but non-compliant letters issued to providers last fall, in Q4-2021. 2)PDSA issued to 12 HNs for not meeting Timely Access Standard in January 2022. Networks are required to complete 3 separate PDSAs: •Improve Member Access to PCPs •Improve Member Access to Specialists •Improve Telephone Access to Medi-Cal pop. •Technical Assistance calls held February 2022 •Reviewed and approved "Plan" section of PDSAs	1) Final results from 2021/22 Timely Access survey due by July. Review and issue corrective acction to individual providers not meeting timely access standards 2) A&A workgroup to review HNs final PDSA submissions due in June and provide final status and feedback: Completed, Closed, or Other	

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Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) In Q1, the Provider Directory Validation Template was being revised and a new format has now been implemented which PR began using in Q2. 2) Awaiting 2021/22 Timely Access Survey results from vendor with estimated arrival date in July.	1) Provider Relations has 9% or 115 contracted TINS (780 unique providers) validations to date. Provider Relations and Provider Data Management Services (PDMS) continues to complete analysisand update the system of record for the Monthly and Quarterly Provider Data Quality Checks/Audits. 2) Review survey results in summer, and issue letters of noncompliance based on the following escalation order: •Education (1st yr of non-compliance) •Warning (2nd yr ...) •Escalation (3rd yr...)	
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: **Medi-Cal Plan Level:** •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met **Medi-Cal HN Level:** •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: ○PCPs: Met ○Specialists: Not Met •Time/Distance: Not Met **Medi-Cal Timely Access:** •PDSAs issued to 12 HNs for not meeting Timely Access Standard - January 2022 •Continue to field 2021/22 Timely Access Survey	Continue to monitor quarterly If Net Adequacy standard (s) not met, outreach to network to directly. Review HNs final submission for PDSAs in June. Continue to prep for new 2022 Timely Access Survey with target fielding dates, June-November	
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (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 3) Continue to engage work group to address barriers, thereby achieving inctreased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regardign the importance of having a post dischage visit with the members PCP.	12/31/2022	Mike Shook	QIC	MC, OC,OCC	X	No update. Current initiative specific to MC LOBs only	Need follow up meeting to be scheduled to further discuss	
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 will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson	QIC	MC,OC,OCC	X	The HAI scores trended upward in Q4 of 2021, and then had a slight downward trend in Q1 however we are still over a point above the average which is now 4.51 Invoice submission for CHG and Iodophor increase in Q1 however we continue to see nearly 1/3 of the invoices not being submitted per program requirements Of the submitted invoices, we continue to see that more than 50% are not purchasing even half the amount needed to complete the bathing and Iodophor protocols	The PIPQI Program was set to run out its funding in March 2022. The PIPQI Team took and extension to the Board in April 2022. Extension asked for additional $275,000 to extend program through the end of the fiscal year 21-22. New budget based on removing $7500 quarterly incentive Reduce baths from every other day to 2 per week and offer product reimbursement based on that reduction Remove 6 least complaint facilities	
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; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	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 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	5/31/2022	Cathy Osborn/**Scott Robinson**	QIC	MC,OC,OCC	X	**UCI provided:** 1. Consultative service: 12 nursing homes received intensive trainig with weekly feedback of staff saftey metrics; 31 additional OC nursing homes received phone consultation services. 2. Confidential helpline for COVID questions and inquires: To date, 250 helpline inquires have been addressed. 3. Point prevalence sweeps of residents and staff. 4. Monthly progress meetings with CalOptima.	UCI is on track to successfully complete project by 5/31/2022. 1. UCI will continue to provide education to nursing homes. 2. UCI will continue to coduct point prevalence sweeps of residents for multidrug-resistant organisms and analyze results.	

2022 QI Work Plan
(2Q)

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I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 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 April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina	QIC	MC,OC,OCC	X	Strategy is current. We will need to update to align with 2022 HP NCQA requirements and DHCS.	Meeting will be scheduled in 2Q2022 to update.	
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.	Quarterly Adoption of Report	Marsha Choo/Laura Guest	QIC	MC,OC,OCC	X	I. FSR/PARS/NF/CBAS A. FSR • Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022 • Moderate updates to FSR Tool • Substantial updates to MRR Tool • Decrease in number of failed FSR and/or MRR from Q1 to Q2 • Increase in number of CAPs from Q1 to Q2 B. PARS • Significant increase in number of PARS completed from Q1 to Q2 • % of sites with BASIC access increased slightly from Q1 to Q2 C. Quality Oversight - CBAS • Full congregate in-person services scheduled for 10/1/2022 • Virtual audits completed for look back period 2021 II. Credentialing/Recredentialing Subject: Identified in March 2022: Organizational Providers - OneCare Project. For CCN and BH, there were 117 group practices that were identified as not credentialed, although the individual practitioners were credentialed. Actions: As of the end of Q2, 57 completed credentialing. Three providers are in process, 5 were terminated for not meeting credentialing requirements; 41 the application was not received; 2 the requirements were not met and 9 credentialing was not required. III. PQI Subject: Cases leveled at QOC were 20% in Q2; 21% in Q1. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.	I. FSR/PARS/NF/CBAS A. FSR • Educational materials and communications sent in June 2022. (On-site education, CalOptima.org, CalOptima Weekly Communication, Provider Alert-Fax Blast • 2 auditors-1 day or 1 auditor-2 days • Hiring of additional staff to assist with audits and CAPs • Updates to FSR web application completed B. PARS • Educational materials and communications sent in June 2022. (On-site education, CalOptima.org, CalOptima Weekly Communication, Provider Alert-Fax Blast • 2 auditors-1 day or 1 auditor-2 days • Hiring of additional staff to assist with audits and CAPs • Updates to FSR web application completed C. Quality Oversight - CBAS • QI Nurse Specialist-LVN completing virtual audits to review Temporary Alternative Services (TAS) for look back period 2021 • QI Nurse Specialist-LVN to begin on-site CBAS Center visits in September 2022. Goal of 37 contracted CBAS centers by 12.31.2022. II. Credentialing/Recredentialing Actions: Continue to credential the OPs is process. III. PQI Action: Continue with QOC grievance review by RN and MD Concern: Volume of PQIs continue to climb as the number of PQIs have increased and we've had an open nurse position since May. The position will be filled in Q4. The main category of PQIs continued to be Medical Care related to treatment delay, failure, inappropriate or complications. Action: Fair Hearing of PM physician was held in Q2. Second half of the Hearing was held in Q3. Determination will be reported in Q3. The Fair Hearing of the PCP was delayed until Q3 due to the availability of the participants. The second half of the Hearing will be completed in Q3, so we anticipate the determination to be reported in Q3.	
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	Tyronda Moses/Heather Sedillo	QIC	MC,OC,OCC	X	Medi-Cal Complaints: 3% decrease in member appeals; 4% decrease in member grievances; 9% increase in provider appeals from Q1 Medi-Cal Grievances by Category: QOS continues to be the highest Grievance category. QOS decreased by 1.4% from Q1 to Q2. CCN and Veyo continue to have the highest number of QOS grievances. Other Increases: Quality of Care increased by 54% (from 245 in Q1 to 377 in Q2). AltaMed, Monarch, CCN, Arta had the most noticeable increase in QOC grievances. Access increased by 16% (from 503 in Q1 to 585 in Q2) Decreases: Billing decreased by 11.3% from Q1 Medi-Cal BH Grievances: 16% increase in BH grievances; Access increased by 20%; QOS decreased by 7%; Billing decreased by 33% (18 in Q1 and 12 in Q2) OCC Complaints: 56% decrease in appeals; 5% increase in grievances; 8% decrease in provider appeals from Q1 OCC BH Grievances: BH grievances decreased from 6 in Q1 to 3 in Q2 all in the QOS category. OC Complaints: Member appeals increased from 5 in Q1 to 11 in Q2; 16% increase in member grievances (19 in Q1 to 22 in Q2); 46% increase in provider appeals (13 in Q1 to 19 in Q2)	All trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Reommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee. Highest Trends identified during the quarter were related to transportation (late pick ups, no shows and complaints against drivers) GARS continues to work with Veyo to identify barriers and obstacles on a bi-weekly basis	

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Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 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	QIC	MC,OC,OCC	X	In Q2, MemX Committee has reviewed/discussed the following: 4/5/22: •Updates: ○CAPs issued to HNs ○2022 TAS Changes •Charter Approved •Provider Sat Survey •SNC •2022 Workplan Review-deferred	In Q2 MEMX Committee has one meeting scheduled, August 10th.	
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	Utilization Management/ QIC	MC,OC,OCC	X	UMC reported to QIC on 4/12/2022. Presented 2021 4th Quarter andAnnual Trends (12/24/2022), - 4Q 2021 Operational Performance (MC,OC,OCC) -Continue to have some HN/CCN not meeting goal; Only trend noted CCN due to backlog – resolved 1/27/22. - 4Q 2021 Utilization Outcomes (MC, OCC)Medical Measures met Goals - 4Q 2021 Operational Performance WCM goals are to TBD. - Medi-Cal Over/Underutilization Monitoring Dashboard, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM Update, BHI. - DRAFTs of 2022 UM Program, 2021 UM Evaluation and List of Board Certified Consultants (AMR/MRIpA/Internal, with summary of Changes was presented to QIC Committee. - Committee reviewed and approved the 2021 UM Program Evaluation and 2022 UM Program Description as presented.	UMC is scheduled to present 1st Quarter 2022update to QIC on 7/12/2022.	
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	QIC	MC	X	WCM gave a Committee update on the meeting they had on February 15, 2022 and approved the November 16, 2021 WCM CAC meeting minutes. A copy was submitted for QIC to receive and file. Annual Committee Conflict of Interest and Attestation forms were completed. Committee recommended to add Susan Gage, CHOC Pulmonary specialist to the Committee. Case Management Director, Sloane Petrillo presented an update on CalAIM. Approximately 2,000 members were transitioned from Whole Person Care (WPC) Pilot and the Health Homes Program to the new Enhanced Care Management (ECM) program and Community Supports Services Pharmacy Director, Dr. Gericke provided Medi-Cal Rx update with relief of backlog with DHCS decision to remove prior authorization requirement UM, GARS, and CS gave a report on measures.	WCM is scheduled to give Committee update on July 12, 2022.	
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	Sandeep Mital	QIC	OCC	X	Scheduled to give update when we receive final scores from CMS in 2Q of 2023	Continue to monitor performance on the various measures	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps 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	QIC	MC,OC,OCC	X	All MCAS selected measures having MPL requirement achieved MPL except the newly added Well-Child Visits in the First 30 Months of Life measure (W30-15months; W30-30months)	Start health disparity analysis to further refine focus areas	
Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the, scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	Quarterly Report or As needed	Kelly Rex-Kimmet/Sandeep Mital	QIC			Need approval from the Board Of Directors so that we can share the measures and payment methodology with health networks.	Need approval from the Board Of Directors so that we can share the measures and payment methodology with health networks.	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Submitted BCS Health Equity PIP Progress Check-In. Continued testing intervention. Mobile Mammography Event Q2: Completed 25 BCS for KCS CCN members. 2) Submitted W30 PIP Progress Check-In. Continued testing intervention. Provider office has reached SMART aim goal (44.96%).	1) BCS Health Equity PIP Progress Checkin feedback expected in Q3. Continue testing intevention through the end of the PIP December 31, 2022. Scheduled KCS Mobile Mammogrophy Events for for 8/15, and 10/24. 2) W30 PIP Progress Check-In feedback expected in Q3. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022.	
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	QIC	MC,OC,OCC	X	MC QIP 1) COVID QI Phase 2-a. SSD update provided under Quality of Clinical Care Behavioral Health section below.b. CCS - Cycle 2 completed on 6/30/22. Pending tracker results from participating providers. c. CIS Combo 10 completed April-June intervention. Provider Office successfully reconciled 677 records and outreached to 663 members (metric 1). 64 members were scheduled an appointment for this period and 107 members are awaiting the availability of the flu vaccine to complete measure (metric 2). May 2022 CIS-10 PR for proivder office: 41.28%. 2) 2022 June Prospective Rates (PR):Statin Therapy for Patients With Diabetes (SPD)Statin AdherenceMC: 4.65%, OC: 1.85%, OCC: 1.62% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Statin TherapyMC: 67.22%, OC: 76.67%, OCC: 76.90% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL).	1) COVID QI Phase 2- a. SSD b. CCS For cycle 3 Provider Offices staff will still focus on outreaching to members to schedule cervical cancer screening but CalOptima plans to add a provider office staff staff incentive that focuses on provider office cervical cancer screening rate by September 2022. c. CIS Combo 10- Target list for Cycle 4 (07/01/2022 - 09/30/2022) is shared with Provider Office for July - September implementation. Intervention includes outreaching to noncompliant members to schedule appointments, and tracking the number of newly compliant members. a-1) Continue tracking members in need of diabetes screening test. a-2) Continue prescribing provider outreach.	
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Emerging Risk Health Coach Outreach OC CCIP 8 members, 5 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 44 members, 32 Assigned, 6 Unable to Contact, 0 No Longer Emerging Risk, 0 No Longer Eligible. 2) Results pending, final data slated at end of Q4 2022.	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	

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PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman/D. Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PPME (OC): a. HRA's: Q1 completed with 100% outreach for both initial and annual members. Q2 April initials complete with 100%; May and June are pending. Q2 Annual outreach completed at 99%. b. HN MOC Oversight(Review of MOC ICP/ICT bundles) 100% for HRAs reviewed; Care Plans reviewed within 10 business days did not reach benchmark of 90% for quarter. 2) QIPE (OCC): a. HRA's: Q1 Initial outreach completed at 100% and annual at 99%. Q2 initial outreach for Apirl and May is 100% and June is pending. Q2 annual outreach is 99%. b. HN MOC Oversight (Review of MOC ICP/ICT bundles) 100% for HRAs reviewed; Care Plans reviewed within 10 business days did not meet benchmark of 90% for quarter. c. 1.5 ICP initial care plan for high risk members 87% d. 1.5 ICP initial care plan for low risk members 81% e. 1.6 Care goal discussion 99% f. 3.2 ICP within 90 days of eligibility 81% 3) LTSS HRA OCC: Active monitoring and reporting to the manager on outreach completion and timeliness. Q2 27 files reviewed.	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PPME (OC): a. HRA's: Continue monitoring HRA outreach completion rates on monthly basis for both initial and annual. b. HN MOC Oversight(Review of MOC ICP/ICT bundles) Continue with process of HRA review; Care Plans are being reviewed and this data is being tracked monthly and reported to A&O. Oversight process to be restructured as early as Q3 and workplan will need to be modified. 2) QIPE (OCC): a. HRA's: Continue monitoring HRA outreach completion rates on monthly basis for both initial and annual. b. HN MOC Oversight (Review of MOC ICP/ICT bundles) Contine with process of HRA review; Care Plans are being reviewed and this data is being tracked monthly and reported to A&O. Oversight process to be restructured as early as Q3 and workplan will need to be modified. c& d. Continue to track MMP 1.5 results on quarterly basis. e. Continue to track 1.6 Care goal discussion on quarterly basis. f. Continue to track MMP 3.2 ICP and identify any logic concerns that can explain the drop from 85% benchmark that was met in 2021. 3) LTSS HRA OCC: Continue review of HRA for LTSS on monthly basis.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson	QIC	MC	X	BHIIP: 1) Prepared and completed Program Year 2 Q1 milestone report 5/3, due to DHCS 5/27/22 2) Reviewed provider group's revisions to the issued CAP; resolution was for the group to revise their milestones to be more obtainable and able to report. 3) MOU amendments were issued to DHCS for 2 provider groups (1 group opted-out of the program, 1 group revised their milestones). 4) Milestone incentive payment funding was received from DHCS for Q2 and Q3 2021; check requests processed and incentive payments distributed to the provider groups. Q4 recieved in June and check request being processed. ABA P4V: 1) Prepared check requests for the 73 provider groups who met their targeted goals, checks were mailed week of 4/4/22	BHIIP: 1) Q2 2022 Milestone Reporting Template due 8/27/22 2) 2021 Performance Measures/Baseline Report due 8/29/22 3) Q4 2021 Milestone Incentive Payments to be distributed ABA P4V: 1) Planning to revise/update Tableau report in order to distribute a P4V report card to the ABA provider groups to show their status of the performance metrics from Jan thru June 2022. Targeting distributing report card by end of August.	
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. (CM) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration, member housing supports, and homeless services for members	Quarterly Report	Katie Balderas/Gail McMillen	QIC	MC,OC,OCC	X	OCC BH Grievances: BH grievances decreased from 6 in Q1 to 3 in Q2 all in the QOS category.	1) The HRT is preparing to return into the field in Q3, and will be establishing new partnerships with American Family Housing Casa Paloma, the Hope Center in North OC, and other homeless service provider to provide expanded services and care coordination for unhoused CalOptima members. 3) RFP will launch in July 2022 to identify street medicine providers that will implement street-based outreach and healthcare services by end of Q4. 4) CalOptima will develop HHIP Investment plan and submit to DHCS by September 30, 2022. CalOptima will also seek to increase integration with HMIS to increase members access to housing-related services.	
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Mia Arias/Andrew Kilgust	QIC	MC	X	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process: Ongoing Q2 reporting due internally to RAC on 8/8/2022. 4) Establish oversight strategy for the CalAIM program	CalAim updates will be provided by Business Integration starting 3Q.	
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	Katie Balderas	QIC	MC, OC, OCC	x	In January 2022, the Health Equity & SDOH Workgroup formed, comprised of CalOptima staff from a variety of roles and departments. The workgroup co-created a working definition of health equity, reviewed a number of existing health equity frameworks, and drafted a framework for CalOptima's health equity efforts that involves five core areas: 1) Organizational Commitment, 2) Assess & Build Organizational Capacity, 3) Use Data & Narrative to Describe Inequities & Root Causes, 4) Design & Implement Strategies to Transform Practices, Policies, and Systems, and 5) Track Progress, Share Learnings & Strengthen Capacity. In the FY 2023 Budget, CalOptima's Board of Directors approved a Chief Health Equity Officer position. Additionally, CalOptima staff are currently reviewing the NCQA Health Equity Plus Accreditation Standards.	The Health Equity & SDOH Workgroup will gather data on the utilization of SDOH Z-Codes, with a focus on increasing screening, documentation, and resource referrals for individuals who need additional supports for their SDOH. The Workgroup is also planning a staff survey to gather information on health equity learning needs. CalOptima will work with the consultant and impacted departments towards the development of an plan for Health Equity Plus Accreditation in Q3.	
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo/Katie Balderas/Kelly Rex-Kimmett	QIC	MC, OC, OCC		Presented the DHCS Comprehensive Quality Strategy to the Quality Improvement Committee to share DHCS' vision.	Will present the DHCS Comprehensive Quality Strategy (CQS) to the September Quality Assurance Committee. QI Staff will begin to draft the QI Program and align it with the CQS.	

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Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW} to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	12/31/2022	Natalie Zavala	QIC	MC		1) Continued collaboration with with Orange County Department of Education (OCDE) and OC Health Care Agency (HCA). Attending weekly Mental Health Superintendent Work Group. 2) Continued collaboration with School Districts (SDs). Held 2nd meeting SD Workgoup April 19th to review expectations and begin assessment phase of program. Holding bi-weekly office hours to support SD in completing Needs Assessment Template. 2) Provided update at the following meetings: WCM Clinical Advisory Committee (CAC) 5/17; WCM Family Advisory Committee (FAC) 4/26. 3) Continued weekly internal meetings with Core Team.	1) SDs to submit Needs Assessment Template responses by 7/15. 2) Continue routine meetings with OCDE and OC HCA. 3) Hold external stakeholder workgroup next quarter.	
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 6/30/22: BCS: 239 for MC 2 for OCC and 4 for OCC; CCS: 400 for MC; COL: 4 for OC an 3 for OCC 1b. Transition to Member Health Reward Vendor Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2. Pending complete transition to member health reward vendor to define and set deadlines to implement. 3. Member Engagement Strategy: Texting: BCS texting campaign total= 4,788 Social Media (Passive): BCS, CCS, COL Static Social Media Post for National Cancer Control Month; BCS, CCS National Women's Health Week Social Media (Paid): COL, CCS Digital Ad: CCS digital ad; COL digital ad Print Ad: COL print ad Direct Mailing: 618 COL OC and 2,906 COL OCC member mailing Community Connections: BCS, CCS, COL April is National Cancer Control Month article MC Member Newsletter: CCS How to Protect Yourself from Cervical Cancer 4. Community Events: Mobile Mammography: KCS event 25 CCN members completed 5. 2022 June Prospective Rates (PR): Breast Cancer Screening MC: 51.03%, OC: 58.57%, OCC: 57.68% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 48.67% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 43.07%, OCC: 47.95% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Complete transition to member health reward vendor is set to be executed by August 2022. 2. Targeted member engagment and outreach campaigns to identified zip codes. 3. Member Engagement Texting: BCS texting campaign scheduled Q3/Q4 IVR: BCS scheduled for Q3/Q4 Social Media: BCS scheduled for Q3/Q4 Digital Ad: BCS scheduled Print Ad: BCS scheduled Direct Mailing: CCS, BCS, COL scheduled for Q4 Community Connections: Article scheduled for Q3/Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue Live Call Campaign: Pending new contract 4. Community Connections: Ongoing mobile mamography events	
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1. COVID texting campaigns continued in Q1 2. Vendor has processed a total of 604,521 incentives (cumulative) Processing Totals As of 7/27/2022, processing totals (not unique member count) are as follows: • Vendor has processed a total of 854,755 incentives (cumulative). o Vendor is still working on processing the recent batch print (once done, will update processed #s). • PHM has processed a total of 149,643 incentives (cumulative). o PHM will be working on processing OC in-house (once done, will update processed #s). •Total: 1,004,398 3. VIP reimbursement data requested for Phase 2 submission	1) Texting campaigns continue. New texting messages will be updated to include expanded age ranges and booster shot eligibility. 2) COVID community vaccine events are planned in partnership with CHOC Future Vaccine Events: August 18, September 17 Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. Social Media, Targeted ad campaigns scheduled. COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing.	
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q2 (May): 30 day- 30.30%, 7 day- 18.18%; BHI real-time report April - June: 30 day- 50%, 7 day- 46% . 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Difficulties included: Higher rate of readmissions among members, members not attending follow-up appointments due to readmission; members declining assistance from PCC or IP facility in assisting member with creating OP BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	
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.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q2 (May): Initiation Phase- 42.36%, Continuation and Maintenance Phase- 46.81% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member f/u visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Treatment for Children with ADHD (submitted October 2021) article intended to educate members on ADHD did not make it into the 2022 CalOptima Member Spring Newsletter per Communications. Article not able to be included until 2023 Spring edition. BHI to look at alternative ways to share information with members. 4) Received updated compliant and non-compliant provider list.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters.	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW} to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q2 (May): M/C: 47.84%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' PCP name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Difficulties: attaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. 3) Working with ITS to develop ongoing report to identify and monitor members and their prescribing providers. Currently, reports are done by request and require manual maintenance.	1) Continue tracking members in need of diabetes screening test. 2) Continue prescribing provider outreach.	

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Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q2 (May): 30 day- 26.86%, 7 day-16.81% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. 1) Working with ITS to develop report to analyze trends on ED visit data.	1) Finalizing Completion of Tableau report on member ED visits to identify trends. 2) Attend at least 1 HN Quality meeting to discuss/ address barriers.	
IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 212 Processed, 193 approved, 19 denied 1b) Transition to Member Health Reward vendor (Icario). Contract with vendor fully executed on 2/14/22. Tentative Go Live date slated for 8/1/2022. Communication Stretegy being finalized, reward process design in progress. 2) Emerging Risk Health Coach Outreach: MC 513 members, 328 Assigned, 1 No Longer Eligible, 28 No Longer Emerging Risk, 2 Opt Out, 28 Unable to Contact OC 8 members, 5 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 44 members, 32 Assigned, 6 Unable to Contact, 0 No Longer Emerging Risk, 0 No Longer Eligible. 3) Member Engagegment Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachble/no answer Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 June Prospective Rates (PR): Note: A1C Testing submeasure was removed from 2022 HEDIS specs. A1C Adequate Control <8.0 MC: 27.75%, OC: 32.67%, OCC: 41.27% Measure is performing higher for all LOBs than same time last year except for OC LOB and below the 50th percentile (MPL). A1C Poor Control >9 MC: 67.12%, OC: 61.63%, OCC: 52.20% Measure is performing better for all LOBs than same time last year (lower rate is positive trend) except for OC LOB and below the 50th percentile (MPL).	1) Track and monitor until the end of member incentive year.Complete transition to member health reward vendor is set to be executed by August 2022. Tentative Go Live date slated for 8/1/2022. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q3-Q4 2022.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 101 Processed, 85 approved, 16 denied 1b) Transition to Member Health Reward vendor (Icario). Contract with vendor fully executed on 2/14/22. Communication Strategy being finalized, reward process design in progress. 2) VSP Eye Exam Reminder Letters slated for Q3/Q4 2022 distribution 3) Member Engagegment Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachble/no answer Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 June Prospective Rates (PR): Diabetes Eye Exams MC: 39.19%, OC: 50.23%, OCC: 53.55% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year.Complete transition to member health reward vendor is set to be executed by August 2022. Tentative Go Live date slated for 8/1/2022. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q3-Q4 2022. 6) Pending feedback from 1 HN to finalize VSP data fields.	
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	12/31/2024	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson/ Joanne Ku	QIC		X	CMO is supportive of developing a new, innovative diabetes program, but he recommended that we conduct user research first to clarify what really would benefit our members with poorly controlled diabetes. Therefore, the multidispclinary diabetes workgroup decided to revisit the program design and narrow down the target population. Prototyping with a small sample (n=20) would help the workgroup answer the critical questions around the pilot program's desirability, feasibility, and viability. The workgroup has been meeting bi-weekly and plans to conduct a few key informant interviews with community leaders so we can learn more about our target population and build a pilot program that has our community partners' input and insights. Due to the change in direction, updates for the Member Health Rewards CCN Pilot will be discontinued moving forward. For provider side, the workgroup also decided to look for other ways to support provider offices and collaborate. Therefore, we will not be providing incentives, but we will identify provider champions who would like to work with us to provide more coordinated care for our members with poorly controlled diabetes.	The workgroup will move forward with having key informant interviews to learn more about our target population and see what tailored interventions would be helpful to them. The workgroup is also planning to integrate Community Health Workers (CHWs) into the intervention. We are hoping to have CHWs as part of the interdisciplinary team so they can help us thinking about what we are doing to best serve our members (shifting the focus from just checking the boxes). We are also considering having an introductory meeting with high volume PCPs and Endocrinologists so we can identify a couple of provider champions to launch this pilot together. The goal is to launch the pilot by Q4 of 2022.	

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V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	QIC	MC	X	1) Member Health Reward of $50 for Postpartum Care visit within 1-12 weeks after delivery is continuing. 2) Process for the first quality Initiative mailing is being finalized. First mailing projected date moved to go out in Q3 2022, not Q2 2022 as anticipated. Mailing will target members that recently delivered (identified via and encourage timely postpartum care. 3) Bright Steps Program conducted initial outreach to 781 unique members for a total of 1,278 outreach attempts. 1,179 outreach attempts made to 760 for postpartum members, 263 postpartum assessments completed. 4) Targeted digital social media campaign for Prenatal Care ran through May - June 2022. Digital ads received a total of 430,279 impressions for English, Spanish, and Vietnamese altogether. Social Media ads for Prenatal care ran May - June 2022 and reached 85,953 persons, and made 126,878 impressions (English, Spanish, and Vietnamese). 5) Bright Steps Program received a total of 996 new Pregnancy Notification Reports and conducted outreach to engage members with the program. 6) Total # of PPC health rewards approved through Q2: 146. 7) Implemented a series of four Diaper Day events in collaboration with CalFresh and community partners. A total of 66,846 diapers distributed. 8) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. June 2022 Prospective Rates: Timeliness of Prenatal Care: 79.97% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 62.21%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin Q3 2022. 2) Prenatal and postpartum social media campaign is projected to extend through Q3 2022. 3) Prenatal and postpartum text campaign is projected for Q3 2022. 4) Exploring how the approved Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care.	
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2 Newsletter, Well-Child Visits Flyer and Lead Poisoning Fact Sheet mailing went out 4/26/22 to 27,346 members. - Targeted ad campaign for Well-Care Pediatrics April - June 2022. Digital = 814, 522 impressions; Social Media = 468,182 impressions. - April World Immunization Week (WIW) observance on social media. Including a Health Care Chat video 4/28/22. - Community Connections April Newsletter 4/20/22 for World Immunization Week observance. - Medi-Cal member newsletter article on adolescent immunizations dropped 4/27/22. - Live call campaign for mid-year push for well-child and immunization measures. Well-Child (0-30 Months) Robocall Campaign dropped 6/13 - 6/16/22 to 3,070 members. Well-Care (12-17 Years) Robocall Campaign dropped 6/20-7/1/22 to 24,603 members. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Attended Pretend City School Readiness Fair 3/26/22 and YMCA Health and Wellness Event on 5/1/22 to promote health education. Continuing outreach to CBOs and Clinics to confirm back-to-school vaccination events. 6 events are confirms for July-August 2022. 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices. 4) June 2022 Prospective Rates: CIS Combo 10: 29.57%; has not met MPL. Rate is lower than last year. IMA Combo 2: 41.90%; met MPL. Rate is higher than last year and has met 66th percentile (41.81%) W30 First 15 Months: 25.41%; have not met MPL (54.92%). First year with benchmarks to monitor PR. W30 15-30 Months: 63.81%; have not met MPL (70.67%). First year with benchmarks to monitor PR. WCV: 21.40%; have not met MPL (45.31%). First year with benchmarks to monitor PR.	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Texting campaign and social media campaign for National Immunization Awareness Month - Health Guide 7-12 mailing - Targeted ad campaign for pediatric immunizations - Plan for PBS Kids ads 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics - Execute planned back-to-school events - Event promotion: website, targeted member mailing, text message campaign, boost social media post 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in April 2022 to health networks with Q1 2022 data on members that have not been screen as recommended for blood lead screening. Q1 2022 report for CCN Providers shared via Provider Portal. 2) Targeted digital campaign efforts: blood lead screening campaign on social media run May - June 2022. Digital campaigns had a total of 430,279 digital impressions. Social media targeted ad campaigns had a total reach of 106,960 (Eng, Spa, and Viet) and had a total of 150,849 impressions. 3) Prop 56 provider value based payments for Blood Lead Screening. 4) CalOptima Policy Blood Lead Screening of Young Children GG.1717 revised to include preliminary DHCS audit results intended to improvide Provider adherence to anticipatory guidance for blood lead screenings. June 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performanc level- MPL). MC: 56.82% Measure is performing higher than the same time last year and has not met the 50th percentile. (MPL)	1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Reports are in process of being revised to highlight provider requirements such as the need for anticipatory guidance to parent/guardian of members. 2) Preparing to offer two Provider CME events focused on blood lead screening requirements. 3) Blood Lead IVR call campaign is being prepared to launch July 2022. 4) Blood lead member text campaign is planned to launch during Q3.	
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	MC,OC,OCC	X	CalOptima reviewed the OON results by HN and determined that a large volume of OON requests were requests made by HNs and not CCN. CalOptima has already reached out to 2 HNs to address this issue.	Staff is working to develop regular reporting to share HN specific OON performance with the HN as part of the Subcontracted Network Certification Summary Quarterly Report and request that all HNs identify the 3 areas/provider types with the most OON requests and how they plan to address this concern.	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC		Reaching Goal. PR is currently at a 33% using the new updated template for the provider directory. Submissions of the open/close panels continue to be received by PR until end of Q4.	PR Reps are meeting with provider offices to ensure provider directory validations are being returned; PR Rep and PR Director meeting with FQHC's, Lunch and Learn scheduled for first week of October to alert providers of open/closed panel topic.	

2022 QI Work Plan
(2Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	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
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) No action was taken in Q2 as the 2021 Timely Access Survey was in the field. Upon receive of the results and the provider level detail file, non-compliant letters will issued to providers in Q3. 2) Received PDSA submissions from all 12 HN on the three Timely Access PDSAs. PDSAs are current under review.	1) Review and conduct quality checks to the 2021-22 Timely Access Results. Upon completion of the review, letters will send to providers and corrective actions letters to individual providers with 3 consecutive instances of non-compliance. 2) Access workgroup to review HNs submission and close out and/or determine next steps for HN.	
Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Reaching goal. PR is currently at a 33% using the new updated template for the provider directory. Submissions of the open/close panels continue to be received by PR until end of Q4. 2) 2021/22 Timely Access Survey fielding occurred during Q2 and results will be made available in Q3. Analysts will be conducting quality checks of the data for accuracy.	1) PR Reps are meeting with provider offices to ensure provider directory validations are being returned; PR Rep and PR Director meeting with FQHC's, Lunch and Learn scheduled for first week of October to alert providers of open/closed panel topic. 2) Once data has been thorougly reviewed, staff will issue non-compliant letters to providers. Target fall-2022	
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: Medi-Cal Plan Level: •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met Medi-Cal HN Level: •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: -PCPs: Met -Specialists: Not Met (Arta, KP, Monarch) •Time/Distance: Not Met Medi-Cal Timely Access •Received repsonses to all three individual Timely Access PDSAs from all 12 HNs •HNs were provided a quarterly Subcontract Network Certification Summary report with their HN network adeuqacy performance. •Continued to work with all HNs to identify providers in and out of their HN to ensure coverage for their members. •Closed out fielding 2021/22 Timely Access Survey in July1	Continue to monitor quarterly and notify HNs of areas of non-compliance. If Net Adequacy standard(s) not met, HNs will identify out of network providers to ensure coverage of services. Review HNs final submission for PDSAs by end of third quarter. Access Workgroup to review responses and close-out and/or determine next steps. Workgroup to discuss how to certifiy HNs and how to issue corrective action to HNs with non-compliance.	
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (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 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Mike Shook	QIC	MC, OC,OCC	X	Working with team to develop communication strategy to providers and members related to scheduled post discharge visits with PCP.	Meeting scheduled with Team on 7/19/2022	
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 will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson	QIC	MC,OC,OCC	X	Objectives not met: Due to constraints related to the COVID-19 pandemic Nusing Facility compliance with utilization of CHG and Iodophor remained low throughtout the program. Invoice submission showing proof of product purchase also remained low and despite multiple outreaches and educational opportunities with the facilities, the decision was made by the CalOptima Finance department that there was not enough evidence to support the continuation of the program past the June 30, 2022 date because the clinical outcomes were not as expected.	1) Activites for the program ended on June 30, 2022. 2) All PIPQI created and translated documents remain available to educate NF staff and residents about decolonization protocols 3) All participating PIPQI facilities receivied final training inservice prior to June 30th, 2022.	

2022 QI Work Plan
(3Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	**Target Date(s) for Completion**	Staff Responsible	Report to Committee	LOB	**Con't Monitoring from 2021**	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										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 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 April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Kelly Giardina/Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Kelly Giardina/Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Katie Balderas	QIC	MC,OC,OCC	X	PHM Strategy is currently being reviewed and will be updated to align with CalAIM Population Health Mangagement Strategy. PHM Department will be taking a CalAIM Population Health Management Strategy update to the next QIC.	CalAIM PHM Strategy update will be given at the 10/11/2022 QIC.	
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.	Quarterly Adoption of Report	Marsha Choo/Laura Guest	QIC	MC,OC,OCC	X	**I. FSR/PARS/NF/CBAS** **A. FSR:** Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022; Decrease in number of failed FSR and/or MRR from Q2 to Q3; Increase in number of CAPs from Q2 to Q3 (96 vs.119) **B. PARS** • Decrease in number of PARS completed from Q2 to Q3 (212 vs. 195) • % of sites with BASIC access decreased from Q2 to Q3 (41% vs. 36%) • Backlog of 2021 HVS PARS completed. Outreach Specialists working on 2022 list. **C. Quality Oversight - CBAS** • Full congregate in-person services resumed 10/1/2022 • QI Nurse Specialist-LVN resumed on-site CBAS Center visits in September 2022. Goal of reviewing 37 contracted CBAS centers by 12.31.2022. **II. Credentialing - TBD** A. Identified in March 2022: Organizational Providers (OP) - OneCare Project. For CCN and BH, there were 117 group practices (with an NPI2) that were identified as not credentialed, although the individual practitioners were credentialed. As of Q3, 49% of these providers were credentialed. A query has been submitted to DHCS for guidance on credentialing on group practices. B.Significant increase in volume of credentialing applications to credential from Q1 – Q3, which include OP, CalAIMs and practitioners. C.Fallout report, a report to identify contracted providers not yet credentialed, is in the final stage of testing. (Data compares cactus to facets). Fallout report 90% complete. D.DHCS issued a revised All Plan Letter (APL) on Screening and Enrollment and Credentialing and Re-Credentialing and QI has updated all credentialing policies. Policies were presented to CPRC. E.Process improvements: Update the Request to Credential form and new reports to identify recredentialing **III. PQI** Subject: Cases leveled at QOC were 23% in Q3; 20% in Q2; 21% in Q1. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.	**I. FSR/PARS/NF/CBAS** **A. FSR:** Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022; Decrease in number of failed FSR and/or MRR from Q2 to Q3; Increase in number of CAPs from Q2 to Q3 (96 vs.119) **B. PARS:** Decrease in number of PARS completed from Q2 to Q3 (212 vs. 195); % of sites with BASIC access decreased from Q2 to Q3 (41% vs. 36%); Backlog of 2021 HVS PARS completed. Outreach Specialists working on 2022 list.;C. Quality Oversight - CBAS; Full congregate in-person services resumed 10/1/2022; QI Nurse Specialist-LVN resumed on-site CBAS Center visits in September 2022. Goal of reviewing 37 contracted CBAS centers by 12.31.2022. **II. Credentialing - TBD** A.QI continues to work with Contracting and Provider Relations on the OC project to credential all identified medical groups.; B. Cross train Credentialing Coordinators to credential all credentialing types, practitioner, mid-level, allied, BH, Organizational Providers, CalAIM, ABA and all areas of credentialing (intake, verification); C.Finalize the Fallout Report and utilize to consistently identify contracted providers to credential; D. Review and update the current workflows and update the desktop procedures to reflect a streamlined process.; E. Finalize the Request to Credential (RTC) form and launch the (RTC) form for Contracting to use. Utilize the new recredentialing reports to monitor compliance and streamline recredentialing process to integrate the process for practitioners and organizational practitioners. **III. PQI:** Action: Continue with QOC grievance review by RN and MD. Concern:Volume of PQIs continue to climb as the number of PQIs opened is double that of the same time last year. The main category of PQIs continued to be Medical Care related to treatment delay, failure, inappropriate or complications. Action: Fair Hearing of PM physician was held in Q2. Second half of the Hearing was held in Q3. Determination will be reported in Q4. The Fair Hearing of the PCP was delayed until Q3 due to the availability of the participants. The second half of the Hearing will be completed in Q3, so we anticipate the determination to be reported in Q4.	
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	Tyronda Moses/Heather Sedillo	QIC	MC,OC,OCC	X	Slight increase in total number of grievances in 3Q over 2Q. Attributing to the increase in Q3 were complaints regarding access quality of care, and transportation issues. No specific trends were identified, however we continue to monitor these two areas very closely and also work with QI and Provider Relations to address our findings. **3Q Trending Medi-Cal Grievances:** Access to Care- Appointment availability, Limited resources, Phone/technical issues impacting member's access. Member billing concerns- Billing member for non-contracted HNs, Non contracted groups providing services at the hospitals, Hospitalist group contract termination. Quality of Care- Delay in treatment and lack of follow-up. Quality of Service- Transportation issues- No shows, Early /Late pickup. **3Q Medi-Cal Member Appeals:** Rate/1,000 for Medi-Cal remained constant in 3Q- (259 received), highest amount received from CCN- 90 and Monarch- 46. No significant trends identified; overturns were made based on additional information received to support medical necessity for the requested services. **3Q OCC Member Appeals (Rate per 1000):** Total Member Appeals received increased from 32 to 51 from 2Q 2022 to 3Q 2022 this was primarily related to an increase in member claims denials/reimbursement requests. We continue to promote proactive outreach and identify the members who could possibly benefit from the assistance of a PCC or CM. Due to the low volume of OCC population the overturn rate is always a bit skewed since 1 overturn will cause a significant overturn rate. All denials for OCC which were overturned were due to medical necessity met with additional information and include overturns for specialists' visits and claims denials. **3Q OneCare Member Appeals (Rate per 1000):** The low membership creates a higher rate/1000. Decrease in the total number of appeals received for OneCare in 3Q (4). 1 out of the 4 was overturned based on medical necessity met for Part B medication.	All trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Recommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee. GARS continues to work with Veyo to identify barriers and obstacles on a bi-weekly basis	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 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	K. Jenkins/Marsha Choo/C. Matthews	QIC	MC,OC,OCC	X	In Q3, MemX Committee has reviewed/discussed the following: **8/10/22:** •Updates: ○APL 22-xxx ○ANC Time or Distance •Provider Sat Survey •Member Experience PDSA •CAHPS Medi-Cal MY 2021 Results •Provider tools to educate members on referral/auth process	In Q4 MemX Committee has two meetings scheduled, October 12 and December 8	

2022 QI Work Plan
(3Q)

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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	Kelly Giardina/Teresa Smith	Utilization Management/ QIC	MC,OC,OCC	X	UMC reported to QIC on 7/12/2022. Presented 2022 1st Quarter Annual Trends (5/26/2022), - 1Q1 2022 Operational Performance – Goals are being met for Pharmacy auth, BH Auth, LTSS Inquiry/Auth and Unused Authorization. One caution for TAT for processing of referrals due to the backlog had other than that CalOptima's internal CCN/COD TAT's are above 99% across the board since February. Medical Authorization performance goal ≥ 98%: CCN is below goal for this quarter due to low compliance in January 2022; February and March compliance are above goal. - Q4 2021 Utilization Outcomes – All measures are being met for Medi-Cal and OCC - Q4 2021 Operational Performance WCM – For the select metrics data lags a quarter behind. In identifying the denials reported there's nothing unusual to report. - Medi-Cal Over/Underutilization Monitoring Dashboard, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BHI UM Update, BHI. - Committee reviewed and approved UMC meeting minutes (5/26/22), BMSC Meeting Minutes (2.23.22), BMSC Meeting Minutes (3.23.22), P&T Meeting Minutes (11.18.21)	UMC is scheduled to present 2st Quarter 2022 update to QIC on 10/11/2022.	
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	QIC	MC	X	WCM CAC met August 16, 2022. Follow up action items were discussed and closed. Pharmacy Medi-Cal Rx, Whole-Child Model Measures, Grievance and Resolution Services, and Whole-Child Model Customer Service Inquiries provided quarterly updates. PHM gave an update related to CalOptima Health Homeless Health Initiatives, update related to the Population Needs Assessment, and an update related to COVID-19 vaccination rates amongst CalOptima Health Members, specifically the youngest members from age 0-18. At the next PHM report, the committee wants to see numbers that reflect up through the age of 20 years old to get a more precise pediatric count because that's a time where for hard conditional work CalOptima Health could help the family coordinate their care and transition to adult services. An update on CalOptima Health's three-year plan on Student Behavioral (SBHIP) was given resulting in feedback for CalOptima Health staff to create a page of resource or similar kind of sheet where available resources can be easily located and shared for those working with members. Posting the information on website will to allow for updating information as needed. The next WCM CAC meeting is scheduled for 11/16/22.	WCM CAC is scheduled to presented an udate to QIC on 10/11/2022.	
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	Sandeep Mital	QIC	OCC	X	Scheduled to give update when we receive final scores from CMS in Q2 of 2023	Continue to monitor performance on the various measures	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Improve Network quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Paul Jiang/Sandeep Mital	QIC	MC,OC,OCC	X	All MCAS selected measures having MPL requirement achieved MPL except the newly added Well-Child Visits in the First 30 Months of Life measure (W30-15months; W30-30months)	Start health disparity analysis to further refine focus areas	
Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	31-Dec-22	Sandeep Mital	QIC			CalOptima Health Board of Directors approved the OneCare COBAR on December 1, 2022 with the proposed Part C, Part D, and Member Experience measures for the MY2023 OneCare P4V program	Pay for Value team will start generating monthly Prospective Rate reports for CalOptima Health and all health networks to monitor performance on the OneCare Part C and Part D measures	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Received BCS Health Equity PIP Progress Check-In HSAG feedback no resubmission required at this time. Mobile Mammography Event Q3: Completed 29 BCS for KCS CCN members. Continue to test intervention through the PIP end date, December 31, 2022. 2) W30 PIP Progress Check-In feedback completed in Q3. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022.	1) BCS Health Equity: HSAG TBD submission date for the final PDSA worksheet and Module 4. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022. 2) W30 PIP Progress Check-In feedback expected in Q4. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022.	
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	QIC	MC,OC,OCC	X	**1) COVID QI Phase 2-** a. SSD - SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS - Cycle 2 provider staff incentive completed. Cycle 3 completed on 9/30/22. Pending final provider office rates from participating providers. c. CIS Combo 10- Target list for Cycle 4 (07/01/2022 - 09/30/2022) is shared with Provider Office for July - September implementation. Intervention includes outreaching to noncompliant members to schedule appointments, and tracking the number of newly compliant members. **2)Statin Adherence** MC: 29.56% (below 50th), OC: 30.71% (below 50th), OCC: 34.81 % (below 50th) Measure is performing higher for MC and OCC LOB than same time last year and are below the 50th percentile (MPL). OC performing lower than same time last year and below 50th percentile. **Statin Therapy** MC: 69.23% (above 50th), OC: 78.88% (above 50th), OCC: 79.44% (above 50th) Measure is performing higher for MC and OCC LOBs than same time last year. All LOBs are above the 50th percentile (MPL).	**1) COVID QI Phase 2-** a. SSD - b. CCS - Cycle 3 intervention completed. Pending evaluation of cycle 3 in Q4. c. CIS Combo 10 - Intervention period completed.Will evaluation CIS-10 QIP Cycle 4 (July-Sept) data in Q4 2022. **2) Continue Statin Mailers**	

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Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Emerging Risk Health Coach Outreach OC CCIP 0 members, 0 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 26 members, 21 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 0 No Longer Eligible. 2) Results pending, final data slated at end of Q4 2022.	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's: ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Gail McMillen/S. Hickman/D. Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRA's: Quarter 2 finished at 100% for both initial and annual HRA outreach; Quarter 3 initial is 100% for July; August/September still in process. HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) 1% for Q2; Benchmarks were not met in Q3; Benchmark met at 30 business day TAT for July; and improved to 17 business days for August; September is still pending. 2) QIPE (OCC): HRA's Quarter 2 finished at 100% for initial and annual HRA outreach; Quarter 3 finished at 100% for both initial and annual HRA outreach. HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) 1% for Q2. Benchmarks were not met in Q3; Benchmark met at 30 business day TAT for July; and improved to 18 business days for August; September is still pending. ICP High/Low Risk: MMP 1.5 High risk 89%, Low risk 83%, ICP Completed within 90 days, HN MOC: MMP 3.2 for Q3 is 89%; MMP 1.6 Care Goal Discussion 99% 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion. Members flagged as LTC on HRA outreach had outreach 100%	Continue to Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRA's;MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) Continue to monitor and complete pre-cap on monthly basis. 2) QIPE (OCC): HRA's HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) Continue to monitor and complete pre-cap on monthly basis. ICP High/Low Risk: ICP Completed within 90 days, Care Goal Discussion 99% 3) LTSS HRA OCC: Continue to Monitor for timeliness on outreach for completion.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson	QIC	MC	X	**BHIIP:** 1) Prepared and completed Program Year 2 Q2 milestone report due to DHCS 8/29/22, all expected milestones were completed 2) Prepared and completed 2021 Baseline - Performance Measures report due to DHCS 8/27/22 3) Q4 2021 Milestone Incentive Payments received from DHCS, processed and issued to provider groups 7/5/22 **ABA P4V:** 1) During the ABA Provider webinar held in June, 2021 ABA P4V program results were shared with the meeting attendees: ABAU 2021 - 56.90% / 2020 - 56.13% ABAH 2021 - 51.67% / 2020 - 50.42% 2) There is a correction to what was reported last quarter's update --> Prepared check requests for ~~73~~ groups, the correct number is 57 provider groups received an incentive check	**BHIIP:** 1) Prepare Program Year 2 Q3 milestone report due to DHCS 11/29/22 2) Prepare the Q1 2022 Milestone Incentive Payments expected to receive the funding from DHCS around September 28, 2022 **ABA P4V:** 1) Planning for an internal evaluation of the program's performance 2) Planning to obtain ABA provider groups feedback for the program 3) Establish next steps for program continuance	
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. (CM) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed. - to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration.	Quarterly Report	Sarah Nance/Danielle Cameron	QIC	MC,OC,OCC	X	1) Onsite outreach was started in Quarter 3 at Yale Navigation Center 1x/week for 2 hours per outreach. Virtual and telephonic outreach was continued with the Costa Mesa Shelter and Huntington Beach Navigation Center. Telephonic support by the Homeless Response Team was continued for Members who required the services of the Clinical Field Teams. 2) No support for pre-enforcement activites was requested during Quarter 3. 3) An RfQu was conducted to solicit qualifications from potential providers of the street medicine program. From that process, two providers were selected to operationalize a two-pronged street outreach and medicine program that targeted reaching people experiencing homelessness both unsheltered on the streets (encampments, hot spots, etc) and in local shelters. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well and related county entities. The planning phase is anticiapted to begin in December 2023, with services launching in early 2023. 4) CalOptima Health solicited stakeholder input into an Investment Plan, which identified key investment strategies to tackle the barriers idenfitied in the Local Homelessness Plan. The Caloptima Health Board approved this plan, which was submitted to DHCS. DHCS has indicated that the first payment of $4.1M was transmitted to CalOptima Health in support of this work. The CalAIM community investment team will be distributing these initial funds using the approved Investment Plan.	1) The Homeless Response team will continue increasing their presence in the community by expanding onsite outreach at other shelters and at American Family Housing Casa Paloma. 2) The Homeless Response Team will provide support for pre-enforcement activities as needed and requested. 3) Street Medicine providers will be contracted and will begin the planning process to execute the new program and services. 4) The CalAIM team will continue to implement the Housing & Homelessness Incentive Program, including integration with the local continuum of care and increased referral and access of housing communnity supports. The CalAIM team will also implement the Investment Plan.	
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Mia Arias/Andrew Kilgust	QIC	MC	X	1 & 2. All HHP and WPC members were successfully transitioned to CalAIM ECM without an interruption in service. 3. A DHCS reporting process has been established; ITS leads the data collection and Care Management, LTSS and CalAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up-to-date. 4. An oversight strategy is in development.	The CalAIM team will focus on developing and launching the oversight strategy for the CalAIM program. Many lessons were learned during the first year of implementation and those lessons will inform the oversight strategy going forward. Much of this work will launch in 2023.	
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	Katie Balderas	QIC	MC, OC, OCC	x	The Health Equity Data Action Team looked into the utilization of SDOH Z-Codes and found the following: Provider utilization of SDOH Z-Codes in claims is very low 6.70 % of providers are using SDOH Z-Codes, documents on .45% of total claims/encounters for only 3.14% total members Additionally, there are inconsistent mechanisms for collecting SDOH data across CalOptima. Thirteen known health assessments in Guiding Care, of which 9 include SDOH-related fields No evidence-based, validated SDOH screening tool used consistently across member-facing departments.	Incentivize and encourage utilization of SDOH Z-code screening among providers through annual wellness visits Promote network/provider SDOH screening using evidence-based screening tools (ex: PRAPARE, utilization of SDOH Z-Codes) Utilize the transition to a new care management platform (JIVA) to ask consistent, evidence-based questions across all member-facing departments/ programs and link members to resources for social needs using closed-loop referral system (such as FindHelp, Unite Us, etc.)	

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DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	{NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo/Katie Balderas	QIC	MC, OC, OCC		DHCS Quality Strategy was presented to the September QAC. Created and hired an Executive Director of Quality to focus on developing the quality strategy. CalOptima Health has completed the Population Health Readiness Assessment and drafting a PHM strategy, a part of the overall quality strategy, to implement in 2023. Staff is working with NCQA consultants to eduate staff on Health Equity Standards for Accreditation. Continued efforts to on Phase 3 of CalAIM.	ED of Quality to begin Q1 of 2023. Begin implementation of PHM Strategy in Q1 2023. Develop a timeline for Health Equity Accreditation. Develop a QI Work Plan to address the DHCS Bold Goals. Continued efforts in CalAIM.	
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	**{NEW} to 2022 QI Work Plan** SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.		Natalie Zavala	QIC	MC		1) Continued collaboration with Orange County Department of Education (OCDE) and OC Health Care Agency (HCA). Attended Mental Health Superintendent Work Group. External workgroup meetings did not occur; will once materials from LEAs received. 2) Continued internal meetings with Core Team updating project plan on a bi-weekly basis. 3) Provided update at the Q3 WCM Clinical Advisory Committee (CAC) on 8/16/22. 4) 9/30/22 due date for LEAs to submit SBHIP Assessment materials: Needs Assessment Template, Data Collection Strategy, Referral Process, Resource Maps.	1) CalOptima Health team to compile LEA SBHIP Assessment responses for submission to DHCS by 12/31/22. 2) Continue routine meetings with OCDE and OC HCA. 3) Hold external stakeholder workgroup next quarter. 4) Identify targeted interventions and population, and complete Project Plan for submission to DHCS by 12/31/22.	
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 9/30/22: BCS: 346 for MC 5 for OC and 8 for OCC; CCS: 506 for MC; COL: 6 for OC an 19 for OCC 1b. Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2. Targeted member engagment and outreach campaigns to identified zip codes for paid Social Media Campaigns. 3. Member Engagement Strategy: Social Media (Paid): CCS, BCS Digital Ad: CCS digital ad; BCS digital ad 4. Community Events: Mobile Mammography: KCS event 29 CCN members completed 5. 2022 August Prospective Rates (PR): Breast Cancer Screening MC: 53.24%, OC: 60.10%, OCC: 60.58% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 50.59% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 45.66%, OCC: 51.24% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Transition to in-house member health reward process. 2. Targeted member engagment and outreach campaigns to identified zip codes. 3. Member Engagement Texting: BCS texting campaign scheduled Q4 IVR: BCS scheduled for Q4 Social Media: BCS scheduled for Q4 Digital Ad: BCS scheduled Print Ad: BCS scheduled Direct Mailing: BCS scheduled for Q4 Community Connections: BCS arrticle scheduled for Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue 4. Community Events: Ongoing mobile mamography events	
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1) COVID texting campaigns continued in Q3. 2) COVID community vaccine events were held in partnership with OCHCA ongoing. A. Vaccine Events include: • 8/18/2022: 144 total health rewards • 9/17/2022: 116 total health rewards • 9/21/2022: 107 total health rewards B. Vaccine Event Totals: 367 health rewards 3) Vendor has processed a total of 1,049,633 incentives (cumulative) and PHM has processed a total of 1,202,925 incentives (cumulative) as of 10/6/2022. 4) VIP reimbursement data submitted for part 2.	1) Texting campaigns continue. Upon approval from the Board of Directors (BOD), new texting messages will be updated to include expanded age ranges and incentive eligibility. 2) COVID community vaccine events are continuously planned by Community Relations. 3) Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. Social Media, Targeted ad campaigns scheduled. 4) COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing.	

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III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q3 (August): 30 day- 34.925%, 7 day- 17.46%; BHI real-time report Q3 (July-Sept): 30 day- 38% , 7 day- 22% . 1) Continued outreach by BH Personal Care Coordinator (PCC) to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions. *Barriers included: Decrease in iniitial admissions but increase in member Re-admissions. Members not attending follow-up appointments due to readmission; members declining assistance from PCC or inpatient facility in assisting member with creating outpatient BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	
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.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q3 (August): Initiation Phase- 42.62%, Continuation and Maintenance Phase- 48.15% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member follow/up visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Reviewing data for compliant and non-compliant providers.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters. 4) Submit article on Treatment for Children with ADHD to educate members on ADHD will be included in the Medi-Cal Member newsletter Spring edition.	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	**[NEW} to 2022 QI Work Plan** 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q3 (August): M/C: 63.97%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis don't see their PCP because of trust issues.	1) Finalize new data source through Tableau. 2) Continue tracking members in need of diabetes screening test. 3) Continue prescribing provider outreach.	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	**[NEW] to 2022 QI Work Plan** 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q3 (August): 30 day- 25.69%, 7 day-15.61% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. On 9/7/22, BHI attended CalOptima Health Quality Forum to present on FUM and discuss with HNs their experience, barriers, opportunities for improvement. However, due to time contraints, presentation was rescheduled to next meeting in December.	1) Finalize FUM Tableau report to identify trends. 2) Present FUM data at Quality Forum in December to discuss/ address barriers.	

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IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control- lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	**1a) HbA1c Test Health Rewards**: 338 Processed, 304 approved, 34 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. **2) Emerging Risk Health Coach Outreach**: MC 398 members, 249 Assigned, 5 No Longer Eligible, 28 No Longer Emerging Risk, 3 Opt Out, 7 Unable to Contact OC 0 members, 0 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 26 members, 21 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 0 No Longer Eligible. **3) Member Engagegment Strategy:** Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachble/no answer Social Media: slated for distribution late October 2022 / early November 2022. **4) Prop 56 provider value based payments for diabetes care measures.** **5) 2022 August Prospective Rates (PR)**: Note: A1C Testing submeasure was removed from 2022 HEDIS specs. A1C Adequate Control <8.0 MC: 35.12% (green, below 50th), OC: 41.82% (red, below 50th), OCC: 49.91% (green, below 50th) Measure is performing higher for MC and OCC LOBs than same time last year except for OC LOB and all LOBs are below the 50th percentile (MPL). A1C Poor Control >9 MC: 58.88% (green, above 50th), OC: 50.65% (neutral, above 50th), OCC: 43.07% (green, above 50th) Measure is performing better for all LOBs than same time last year (lower rate is positive trend) except for OC LOB and above the 50th percentile (MPL). (Lower is better)	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. Reward process design in progress. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q4 2022. 4) Contract with health reward vendor was canceled, looking for alternative plan for transition.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 201 Processed, 172 approved, 29 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2) VSP Eye Exam Reminder Letters slated for Q4 2022 distribution 3) Member Engagegment Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachble/no answer Social Media: slated for distribution late October 2022 / early November 2022. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 August Prospective Rates (PR): Diabetes Eye Exams MC: 44.34% (green, below 50th), OC: 55.86% (red, below 50th), OCC: 59.86% (green, below 50th) Measure is performing higher for all LOBs than same time last year except for OC LOB and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. Reward process design in progress. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q4 2022. 4) SFTP setup for HN in progress. 5) Contract with health reward vendor was canceled, looking for alternative plan for transition	
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) Lower HbA1c to avoid complications; 2) reduce emergency department (ED) visits and hospitalizations /readmission rates; 3) improve member and provider satisfaction; and 4) optimize diabetes medication management.	Program Design: 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement	12/31/2024	Nicki Ghazanfarpour/ Jocelyn Johnson/ Joanne Ku	QIC		X	Since the initiative is still in the planning stage, there are no results or metrics to report at this time. However, the workgroup has conducted literature reviews and found that the results support our multidispclinary program approach. 1. Literature demonstrates that pharmacist involvement is effective. 2. Literature indicates that diabetes interventions should include culturally relevant resources, family support, and diabetes self-management skills education.	Community Health Worker (CHW) initiative design in planning stages, staff workflow in progress. 1) The workgroup conducted key informant interviews with community partners. The workgroup plans to go back to community partners and share our final pilot program design. 2) The workgroup is currently working with ITS to build member stratification for this project. 3) The workgroup also plans to host a provider webinar or similar engagement activity (targeted for high volume CCN PCPs) so we can have providers' buy-in and commitment to make this work.	
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	QIC	MC	X	1) Member Health Reward of $50 for Postpartum Care visit within 1-12 weeks after delivery is continuing. 2) Postpartum Mailing Initiative: Process for the first quality Initiative mailing is still being developed. Mailing projected to go out by end of Q4 2022. Mailing will target members that recently delivered (identified via and encourage timely postpartum care. 3) Bright Steps Program conducted initial outreach to 1724 unique members. Total of 1,008 outreach attempts made to 630 postpartum members. 248 postpartum assessments completed. 4) Continuing member engagement strategy: -Postpartum Care digital add campaign August - September 2022 = 206,682 impressions (Eng, Spa, and Viet) -Postpartum Care targeted social media ad campaign August - September 2022 = 142,855 Reach, and made 365,687 impressions - Medi-Cal member newsletter article on Postpartum Care Extension is Here!" dropped 09/07/22. 5) Bright Steps Program received a total of 916 new Pregnancy Notification Reports and conducted outreach to engage members with the program. 6) Total # of PPC health rewards approved July - September: 81 7) Perinatal and Postpartum Bright Steps Program participated in 2 Diaper Day events in collaboration with the Westminster Family Resource Center and WIC Santa Ana location. A total of 350 persons were outreach in these public evens. 8) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. **August 2022 Prospective Rates:** Timeliness of Prenatal Care: 80.00% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 63.63%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin by end of Q4 2022. 2) Continue to expand member engagement strategy to ensure multi-modal approach to include the following elements: text campaigns, IVR robocalls, social media, etc. 3) Exploring integration of the Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care. 4) Contract with health reward vendor was canceled, looking for alternative plan for transition	

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VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Targeted ad campaign for Well-Care Pediatrics August - September 2022. Digital = 206,682 impressions; Social Media = 437,118 impressions. - Targeted ad campaign for Immunizations August - September 2022. Digital = 206,682 impressions; Social Media = 410,377 impressions. - Medi-Cal member newsletter article on "Let's Get Ready for School. Ger your Vaccines" dropped 09/07/22. - Texting campaign and social media campaign for National Immunization Awareness Month. WCV = 9027; IMA = 793 - Health Guide 7-12 mailing, in progress, REQ submitted - PBS Ad: Flu campaign started running in September 2022. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. - Back-To-School Vaccination Event: total of 7 events. 443 families attended CalOptima Health table at these events. 72 vaccinations provided (41 were CalOptima Health members). Vision screening, dental screening and developmental screening were available at select events. - Event promotion: website, targeted member mailing, text message campaign, boost social media post 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices. 4) August 2022 Prospective Rates: CIS Combo 10: 30.37%; has not met MPL. IMA Combo 2: 43.68%; met MPL. Rate is LOWER than last year and has met 66th percentile (41.81%) W30 First 15 Months: 30.85%; have not met MPL (54.92%). First year with benchmarks to monitor PR. W30 15-30 Months: 66.75%; have not met MPL (70.67%). First year with benchmarks to monitor PR. WCV: 30.43%; have not met MPL (45.31%). First year with benchmarks to monitor PR.	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 7-12 Newsletter mailing - Well-Child (0-30 Months) IVR and text message campaign - Well-Care 12-17 Years IVR campaiagn - Well-Care (3-17 Years) Text message campaign - LSC, CIS, W30 in-house call campaign for year end push (noncompliant members) 2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices.	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in July 2022 to health networks with Q2 2022 data on members that have not been screened as recommended for blood lead screening. Q2 2022 report for CCN Providers shared via Provider Portal. 2) Continuing member engagement strategy. Member IVR lead campaign launched in July. Member reach: 1,156 3) Worked on starting provider engagement strategy. Including updates to health networks on matters related to blood lead (e.g., gap reports, HN attestation process, internal policy updates) 4) Conducted member barrier analysis to identify root cause of lack of blood lead tests among members. 5) Prop 56 provider value based payments for Blood Lead Screening. 6) Finalized Evidence of Blood Lead Refusal form and HN Attestation Process for Health Networks to adhere to regulatory requirements that include Provider adherence to the provision of anticipatory guidance for blood lead screenings. August 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performance level- MPL). MC: 58.54% Measure is performing higher than the same time last year and has not met the 50th percentile. (MPL)	1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Reports are in process of being revised to highlight provider requirements such as the need for anticipatory guidance to parent/guardian of members. 2) Continuing strategy to update providers. Preparing to offer two Provider CME events focused on blood lead screening requirements scheduled for Q4 2022. Preparing Provider Press blood lead article for Q4 2022 3) Continue expanding member engagement strategy to include multi-modal approach via: texting, robocalls, social media. Planning PBS TV campaign that is projected to start in Q4 2022. 4) Continue with revisions to internal policy GG.1717 Blood Lead Screening in Young Children to support adherence to regulatory requirements.	

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VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	MC,OC,OCC	X	Transition of recruitment efforts from Contracting department to Provider Relations are finalized	Provider Relations will now be responsible for provider recruitment; created letter templates, created workflow and finalizing all documents to ensure reporting of all recuirtment efforts are documeted	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC		Providers are actively returning the provider validations but delayed for those offices that are not tech savvy, new excel format was provided and assisting with navigating the spreadsheet caused delay	PR Reps continue to obtain confirmation of open and or closed panel, documenting requests via Facets, significant improvement to 70% of total CHCN network	
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1)2021-22 Timely Access Results reviewed and QC'd; working with vendor on development of non-compliance tracker. Non-Compliance letters being updated with CAP for those with non-compliance for a single measure 3 consecutive years. 2) HN Timely Access PDSA's submissions reviewed and additional follow-up requested by workgroup on three networks responses before close-out.	1) Next steps include finalizing non-compliance tracker and templates for letters. Issue non-compliance letters to providers and CAPs to HNs by end of 4th quarter. 2) Obtain clarification from three HNs regarding their PDSA submission. Access Workgroup to review final responses and close-out and/or determine next steps. Present final recommendations to Member Experience.	
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Update- improved provider data of 70% of total CCN provider TIN's acknolweding changes and/or updates to provider data, including phone numbers, office hours and open/closed panels 2) 2021-22 Timely Access Survey results reviewed and QC'd. Working with vendor on finalizating non-compliance tracker to assist with issuing letters to providers.	1) Finalizing last outreach effort for end of year push through office face-to-face visits, and phone calls 2) Finalize non-compliance tracker, issue non-compliance letters to providers, share TAS results in SNC November Report, and issue CAPs to HNs by end of 4th quarter.	
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: **Medi-Cal Plan Level:** •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met **Medi-Cal HN Level:** •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: -PCPs: Met for all HNs, except CHOC IM-PCP -Specialists: Not Met (Arta, Monarch) •Time/Distance: Not Met **Medi-Cal Timely Access** •Timely Access PDSAs were reviewed at workgroup mtg and additional follow-up requested on three networks responses before close-out. •HNs were provided a quarterly Subcontract Network Certification Summary report with their network adequacy performance August 31st •Provided HN with DHCS Provider List to help close the providers gaps for time/distance and MPT standards.	Continue to monitor quarterly and notify HNs of areas of non-compliance. If Net Adequacy standard(s) not met, HNs will identify out of network providers to ensure coverage of services. Seek clarification from three HNs regarding their PDSA submission. Access Workgroup to review responses and close-out and/or determine next steps. Present final recommendations to Member Experience. Workgroup to discuss how to certifiy HNs and how to issue corrective action to HNs with non-compliance.	
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (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 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Kelly Giardina	QIC	MC, OC,OCC	X	1) Leveraging Collective Medical for additional ED/ PCP follow up 2) Pilot ED/ Rounds program to help inpatient facilities with escalations and support to secure pre-discharge appointments 3) Continued meetings to discuss open items and data analysis to shift approach as needed.	Collect Data and write up report send to consultant for review. Follow up meeting with Consultant to review report to be scheduled in 1Q2023.	

2022 QI Work Plan
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I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 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 April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Kelly Giardina/ Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Kelly Giardina/ Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Katie Balderas	QIC	MC,OC,OCC	X	PHM Readiness Deliverables submitted to DHCS in October 2022 and additional clarifications were submitted in December 2022 and approved shortly thereafter by DHCS.	Departments are currently updating policies and procedures in alignment with PHM Strategy. Organizationwide PHM Strategy Steering Committee will launch Q1 2023.	
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.	Quarterly Adoption of Report	Marsha Choo Laura Guest	QIC	MC,OC,OCC	X	**I. FSR/PARS/NF/CBAS: A. FSR:** Drop in FSRs Q3-Q4 (56 to 47); Increase in MRRs Q3-Q4 (46 to 58); Increase in failed FSR and MRR audits Q3-Q4 (7 to 11); Drop in CAPs Q3-Q4 (119 to 109); Increase % of Periodic FSRs completed by due date Q3-Q4 (33% to 41%); 394 CAPs issued in 2022 - 114 Critical Element, 174 FSR, 106 MRR; 505 audits completed in 2022 -37 Initial FSRs, 30 Initial MRRs, 204 Periodic FSRs, 230 Periodic MRRs, 4 MRR Focused Reviews. **B. PARS:** Drop in PARS Q3-Q4 (195 to 175); Increase in % of BASIC access Q3-Q4 (36% to 45%); Working on 2022 high-volume specialist (HVS) PARS list.; 685 PARS completed in 2022, 270=BASIC access 415=LIMITED access, **C. CBAS:** In-person services resumed 10/1/22.; 28 on-site visits in Q4; 35 virtual reviews in 2022. D. **NF:** On-site visits resumed Q3; 27 reviews in 2022; 3 unannounced visits at NFs in 2022. **II. Credentialing:** A. Identified in 03/22: OP - OC Project. CCN & BH, 117 group practices not credentialed, although practitioners were credentialed. As of Q4, 50 providers outstanding. QI meeting with legal to review DHCS's response to query on credentialing of group practices.; B.Significant increase in volume of cred apps to credential from Q1–Q4, including OP, CalAIM and practitioners. Anticipate credentialing of new provider types, such as doulas and community health workers.; C.Fallout report, report to identify contracted providers not credentialed, in final stage of testing; 95% complete; D.Process improvements: Request to credential submitted in 1 inbox to streamline & avoid duplicate submissions. **III. PQI -** Fair Hearings concluded in Q4; CPRC upheld recommendation of Fair Hearing Committees. PM MD terminated and reported to MBC. PCP at hospital-no further action. Q4, QI began reviewing Declined Grievances referred by CS for a PQOC. Added 30 more PQIs/month. Cases leveled QOC were 19% in Q4; 23% in Q3; 20% in Q2; 21% in Q1. PQIs closed in 2022 were 350; 2021 in 767. Cases presented to CPRC were 37 in 2022; 32 in 2021. The % of cases leveled as QOC were 11% in 2021; 18% in 2022.	**I. FSR/PARS/NF/CBAS** A. FSR: Plan to add 2 RN FSR positions in 2023. B. PARS: Plan to add 1 Outreach Specialist-PARS position in 2023. C. CBAS: Complete on-site visits at all contracted CBAS centers. D. NF: Re-evaluate current processes. One LVN retiring 3/1/2023. Other LVN on FMLA 02/23. **II. Credentialing** A.QI working with Legal and business areas on OC project to credential all medical groups. If providers need to be credentialed, analysis performed and effort made prior to termination. B. Cross train Credentialing Coord. to credential all cred types and all areas of cred (intake, verification) - particularly OPs. C.Finalize Fallout Report and utilize to consistently identify contracted providers to credential D. Continue to review and update current workflows and update desktop procedures to reflect a streamlined process. E. Finalize provider Onboarding Packet to include cred app. Utilize new recred reports to monitor compliance and streamline recred process to integrate process for practitioners and OPs. Assign recred and initials to cred coordinators to credential the entire file. Provider groups to be assigned to one cred coordinator. **III. PQI** 1. Review QOC grievances, Declined grievances and PQIs. Assess need for additional staffing to accommodate additional workload. 2. Create report to monitor TAT of Declined Grievance PQIs with goal of MD review completed in 30 days and TAT of PQIs with a goal of MD review completed in 90 days.	
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	Tyronda Moses Heather Sedillo	QIC	MC,OC,OCC	X	Slight decrease in total number of grievances in 4Q over 3Q. . No specific trends were identified, however we continue to monitor these two areas very closely and also work with QI and Provider Relations to address our findings. **4Q Grievance Trending Medi-Cal Grievances:** Access to Care- Appointment availability, Telephone accessibility. Member Billing- Members being billed directly. Quality of Care- Delay I treatment, Lack of follow-up. Quality of Service- Transportation- Driver issues, Early /Late pickup. **4Q Medi-Cal Member Appeals:** Rate/1,000 for Medi-Cal remained constant in 4Q (262 received), highest amount received from CCN- 106 and Monarch- 66. No significant trends identified; overturns were made based on additional information received to support medical necessity for the requested services. **4Q OCC Member Appeals (Rate per 1000):** Total member appeals received remained the same from 3Q (51). Monarch had 21 denials appealed and 9 were overturned for medical necessity. CCN had 14 denials appealed and 8 were overturned based on medical necessity met, 7 related to claims denials and 1 for diagnostic testing. **4Q OneCare Member Appeals (Rate per 1000):** The low membership creates a higher rate/1000. Increase in the total number of appeals received for OneCare in 4Q (9). 4 out of the 9 were overturned based on medical necessity met- 2 related to denial of payments for specialist office, 1 for outpatient surgery and 1 for foot orthotics.	All trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Recommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee. GARS continues to work with Veyo to identify barriers and obstacles on a bi-weekly basis1	

2022 QI Work Plan
(4Q)

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Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 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	Karen Jenkins Marsha Choo Carol Matthews	QIC	MC,OC,OCC	X	In Q4, MemX Committee has reviewed/discussed the following: 10/12/22 •Action Items: ○Invite GARS to Access workgroup mtgs ○Internal workgroup to discuss CAHPS PDSA Process •2022 BH Member Experience Results •Network Adequacy •Provider Satisfaction Survey Resutls •Provider Action for Non-Clinical Issues 12/08/22 •Action Items: ○Close out HN Timely Access PDSAs ○Convene Provider Action workgroup to review data and make decisions moving forward •GARS Update •Network Adequacy •OC/OCC CAHPS Scores •Member Experience workplan	Committee will continue to meet and monitor activities on the 2023 Workplan and as needed	
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	Kelly Giardina Teresa Smith	Utilization Management/ QIC	MC,OC,OCC	X	UMC Q3 2022 Utilization report scheduled to report to QIC 1/17/2023. UMC Q2 2022 Utilization report to QIC on 11/08/2022. - Q3 2022 Operational Performance –	Continue to review utilization reports and trends in quarterly UMC in 2023 and report up through QIC meetings to discuss findings and data analysis to shift approach as needed.	
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	QIC	MC	X	WCM CAC met November 16, 2022 Whole Child Model Network Adequacy report of two HN not meeting DHCS standards. Both are now in compliance. -Reports on WCM measures for Behavioral Health, GARS, UM, and HEDIS Pediatric Measures were presented -OC CCS & CalOptima Health Collaboration:DHCS Integrated California Children's Services & Whole Child Model Dashboard.CalOptima Health data were comparable or better than other health plans -No pharmacy update was needed -DHCS Notice Update: CCS Information Notice 22-04 - Palivizumab for Immunoprophylaxis of Respiratory Syncytial Virus Infection during 2022- 2023 was shared	Will schedule 2023 Meeting dates. The next meeting is scheduled for 2/21/23.	
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	Sandeep Mital	QIC	OCC	X	Scheduled to give update when we receive final scores from CMS in Q2 of 2023	Continue to monitor performance on the various OneCare Connect measures	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Paul Jiang Sandeep Mital	QIC	MC,OC,OCC	X	Scheduled to give updates for Health Network Quality Ratings when we receive final HEDIS and CAHPS scores in Q4 of MY2023	Continue to monitor performance on the various HEDIS clinical measures	

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Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	end of 4Q2022	Sandeep Mital	QIC			CalOptima Health Board of Directors approved the Pay for Value (P4V) OneCare COBAR on December 1, 2022 with the proposed Part C, Part D, and Member Experience measures for the MY2023 OneCare P4V program	Pay for Value team will start generating monthly Prospective Rate reports for CalOptima Health and all health networks to monitor performance on the OneCare Part C and Part D measures from Q1 of 2023	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Mobile Mammography Event Q4: Completed 26 BCS for KCS CCN members. Intervention testing completed December 31,2022 waiting for updated HEDIS rate for December 2022. 2) W30 PIP Progress Check-In feedback completed in Q4. Intervention implementation completed and pending HEDIS rate results for December 2022.	These PIPs are now completing the 3-year period and are being sunsetted with final Module 4 submissions pending in April 2023. 1) BCS PIP Module 4 is due April 2023. Completing rolling 12 month SMART Aim Measure data. Pending updated data due to continuous enrollment specification changes. 2) W30 PIP Module 4 is due April 2023. Currently waiting for data refresh to obtain last few data points to evaluate intervention effectiveness.	
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: **1) COVID QIP Phase 2 -** a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- **N. Zavala** b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	end of 4Q2022	Natalie Zavala Helen Syn	QIC	MC,OC,OCC	X	MC QIP 1) COVID QI Phase 2- a. SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS- Completed. For cycle 3 one of three providers reached 50th percentile for measure and provider office staff incentive was paid out. c. CIS Combo 10. Provider office submitted target list October 2022. Provider office had 75 successful appointments during intervention period, 7/1/22 - 9/30/22. Additionally, 21 newly compliant members during this period. 2) Improving Statin Use for People with Diabetes (SPD) **Statin Adherence** MC: 69.26% (above 50th), OC: 74.84% (below 50th), OCC: 77.20% (below 50th) Measure is performing lower for MC, OC and OCC LOBs than same time last year and are below the 50th percentile (MPL). MC is above 50th percentile. OC & OCC below 50th percentile. **Statin Therapy** MC: 71.43% (above 50th), OC: 81.46% (above 50th), OCC: 81.90% (above 50th) Measure is performing lower for MC and OC LOBs than same time last year. Measure is performing lower for OCC LOB than same time last year. All LOBs are above the 50th percentile (MPL).	a-1) Continue tracking members in need of diabetes screening test. a-2) Continue outreach to prescribing providers. b- QIP complete. For RY 2022, MCPs not required to submit COVID-QIP. Pending delivery of provider staff incentive for cycle 1 and 2 for other provider office. c- Pending data availability. Evaluation intervention effectiveness which includes provider office's final CIS Combo 10 rate (administratively). 2) Completed 3-year period on 12/31/2022, will end this initiative. It was confirmed that a QIP is not a DHCS nor a CMS Medicare requirement for 2023.	
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Emerging Risk Health Coach Outreach OC CCIP 6 members, 3 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 24 members, 13 Assigned, 0 Unable to Contact, 2 No Longer Emerging Risk, 1 No Longer Eligible. 2) 2022 baseline was set at 26.02%, represents the rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measure. The goal of this intervention is to reach the target goal of ≤21.02% (a lower percentage is an improvement) a 5-percentage point decrease. The rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measures was 15.46% at the end of 2022 and met the target goal of ≤21.02%.	1) Completed 3-year period on 12/31/2022, will end this initiative. 2) Completed 3-year period on 12/31/2022, will end this initiative.	

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PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Quarterly/Annual Assessment	Sherry Hickman Denise Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles) HRA outreach for Annual 100%; Initial outreach 100% for October and November; December still in process; HRA reviewed 100% prior to sending to the networks; TAT for bundle review: October files met 90% at 15 business days. November files met at 95% at 20 business days; December is in process. 2) QIPE (OCC): HN MOC Oversight(Review of MOC ICP/ICT bundles) HRA's: Completed outreach for Initial HRA 100%. Completed outreach for Annual HRA 100%. Members have transitioned to OC and OCC has sunset. HRAs reviewed 100% by oversight prior to sending to the networks. TAT for bundle review on return: Octobers files met 92% at 15 days; November files met 96% at 25 days; and December is in process. 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion. All LTSS HRAs outreach completed. 4) Monitor CA MMP 1.5 High risk 89% and low risk 83% for Q4 and may change prior to regulatory submission in 2/2023 5) Monitor results CA 1.6 99% 6) Monitor results MMP 3.2 81% as of 1/18/2023, and may change prior to regulatory submission.	1) PME (OC): HRAs: This process is changing and will no longer be a goal in 2023. 2023 will move to benchmarks for collection of an HRA and ICP within 90 days for newly eligible members. Our interventions will reflect regulatory expectations for 2.1 and 3.2 regulatory measures. 2) QIPE (OCC):HRA's: This will not carry over to 2023 as OCC sunsets on 12/31/2022. 3) LTSS HRA OCC: Resolved and will fall off the QI work plan for 2023. 4) MMP 1.5 will fall of the QI work plan for 2023. 5) CA 1.6 will fall off the QI work plan for 2023. 6) MMP 3.2 will continue in 2023 work plan with benchmark of 90%	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala Sheri Hopson	QIC	MC	X	BHIIP: 1) Program ended 12/31/22, only administrative activities remain and will be completed during Q1 2023 2) Prepared Program Year 2 Q3 milestone report 11/9/22, due to DHCS 11/29/22 2) Prepared the Q1 2022 Milestone Incentive Payments 10/13/22, payments issued to the provider groups 10/21/22 ABA P4V: 1) Program ended 12/31/22 per executive leadership directive, administrative activities remain and will be compled during Q1 2023 2) Prepared program ending email notification for the ABA providers; forwarded the notification to Provider Relations requesting it be emailed to all the ABA provider groups by 12/15/22 (request has been confirmed as completed). 3) Finalized reporting configurations for BH P4V report card distribution using the provider portal	BHIIP and ABA P4V commenced on December 31, 2022	
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. (CM) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration, member housing supports, and homeless services for members	Quarterly Report	Sarah Nance **Danielle Cameron**	QIC	MC,OC,OCC	X	1) Onsite continued in Quarter 4 at Yale Navigation Center 1x/week for 2 hours per outreach and at Casa Paloma. Virtual and telephonic outreach was continued with the Costa Mesa Shelter and Huntington Beach Navigation Center. Telephonic support by the Homeless Response Team was continued for Members who required the services of the Clinical Field Teams. 2) No support for pre-enforcement activites was requested during Quarter 4. 3) An RfQu was conducted to solicit qualifications from potential providers of the street medicine program. From that process, two providers were selected to operationalize a two-pronged street outreach and medicine program that targeted reaching people experiencing homelessness both unsheltered on the streets (encampments, hot spots, etc) and in local shelters. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well and related county entities. The planning phase began in December 2023, with services launching in early 2023. 4) CalOptima Health solicited stakeholder input into an Investment Plan, which identified key investment strategies to tackle the barriers idenfitied in the Local Homelessness Plan. The Caloptima Health Board approved this plan, which was submitted to DHCS. DHCS has indicated that the first payment of $4.1M was transmitted to CalOptima Health in support of this work and the second payment of $8.3M was authorized to CalOptima Health. The CalAIM community investment team will be distributing these initial funds using the approved Investment Plan.	1 - HRT will be ending at the close of 2023. These services are provided by a number of other organizations and CalOptima Health is designing a more effective way to use these team members' time. 2 - Support for pre-enforcement activities will discontinue with the disbanding of HRT. These services are also provided by other entities within Orange County. 3 - Street medicine services will launch on 4/1/2023 in Garden Grove. 4 - HHIP newly funded projects will launch 4/1/23.	

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CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Mia Arias Andrew Kilgust **Danielle Cameron**	QIC	MC	X	1 & 2. All HHP and WPC members were successfully transitioned to CalAIM ECM without an interruption in service. 3. A DHCS reporting process has been established; ITS leads the data collection and Care Management, LTSS and CalAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up-to-date. 4. An oversight strategy is in development.	The CalAIM team will focus on developing and launching the oversight strategy for the CalAIM program. Many lessons were learned during the first year of implementation and those lessons will inform the oversight strategy going forward. Much of this work will launch in 2023.	
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	Katie Balderas	QIC	MC, OC, OCC	x	Focus for Q4 was on submitting the DHCS PHM Strategy Readiness Deliverables, which center health equity and will enhance member connection to SDOH. Received demo of closed-loop referral tools for social needs and began drafting scope of work for RFP. Reviewed evidence-based SDOH assessments to include in future member care coordination efforts.	Health Equity workgroup will reconvene in Q1 to determine objectives for 2023. This objective will be sunset in lieu of one focused on food security as a social determinant of health.	
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo Katie Balderas	QIC	MC, OC, OCC		The Comprehensive Quality Strategy is being operationalized through the CalAIM Population Health Management (PHM) Strategy. PHM Readiness Deliverables submitted to DHCS in October 2022 and additional clarifications were submitted in December 2022 and approved shortly thereafter by DHCS.	Departments are currently updating policies and procedures in alignment with PHM Strategy. Organizationwide PHM Strategy Steering Committee will launch Q1 2023.	
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.		Natalie Zavala Carmen Katsarov	QIC	MC		1) BHI completed and reviewed the SBHIP Assessment Components (stakeholder meeting atttestation, data collection strategy, needs assessment, LEA/community resource map and LEA/external provider behavioral health referral process) submitted to DHCS 12/27 2) 4 Targeted interventions discussed and the selection of 4 agreed upon by BH, OCHA, and external partner (CHOC) 3) 4 Project Plans completed - one completed for each targeted intervention selected, submitted to DHCS 12/27 4) SBHIP presented during the Advisory Committee meeting - 12/8	1) DHCS will provide status and score for the submitted SBHIP assessment components, expected in April 2) BH will continue conducting project planning sessions to identify significant implementation needs for each targeted intervention 3) Conduct discussions with Contracting re the development of MOU, Contract, and scope of work templates 4) Continue regular meetings with OCHA, CHOC, and OCDE	

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II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 12/31/22: BCS: 490 for MC 9 for OC and 23 for OCC; CCS: 695 for MC; COL: 5 for OC and 38 for OCC 1b. Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2. Targeted member engagment and outreach campaigns to identified zip codes for paid Social Media Campaigns. 3. Member Engagement Strategy: Social Media (Paid): BCS Digital Ad: BCS digital ad Print Ad: BCS print ad Radio Ad: CCS radio ad Television: PBS-Women's Cancer Screenings (BCS/CCS) 4. Community Events: Mobile Mammography: KCS event 26 CCN members completed 5. 2022 November Prospective Rates (PR): Breast Cancer Screening MC: 56.31%, OC: 63.94%, OCC: 63.69% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 53.05% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 49.00%, OCC: 54.98% Measure is performing lower than same time last year for OC and higher than same time last year for OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Transition to in-house member health reward process. 2. Targeted member engagment and outreach campaigns to identified zip codes. 3. Member Engagement Texting: CCS texting campaign scheduled Q1 IVR: BCS scheduled for Q1 Social Media: CCS, COL scheduled for Q1 Digital Ad: CCS scheduled for Q1 Print Ad: COL scheduled for Q1 Radio Ad: CCS schedule for Q1 Television: PBS Women's Cancer Screening (BCS/CCS) scheduled Q1 Direct Mailing: CCS scheduled for Q1 Community Connections: CCS arrticle scheduled for Q1 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue 4. Community Events: Ongoing mobile mamography events 5. Pending further details from CalOptima Health Comprehensive Cancer Screening Program for 2023.	
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1) COVID texting campaigns continued in Q4. 2) COVID community vaccine events were held in partnership with OCHCA ongoing. A. Vaccine Events include: • 10/8/2022: 55 total health rewards 3) Vendor has processed a total of 1,049,633 incentives (cumulative) and total processed (including in-house processing) is 1,209,806 incentives (cumulative) as of 1/6/2023.	1) Texting campaigns continue. CalOptima Health's Board of Directors approved new incentive guidelines of providing up to 4 health rewards with end date for unvaccinated members. New texting messages will be finalized to include incentive eligibility. 2) COVID community vaccine events are planned by Community Relations. 3) Ongoing COVID messaging to go out in Member Newsletters and Provider publications about the importance of updated booster vaccinations and new approved health reward eligibility guidelines. Social Media, Targeted ad campaigns scheduled. 4) COVID vaccine incentive processing continues, CAIR2 registry data and logic improvements to assist with identification and more timely processing. 5) COVID VIP will end June 30, 2023 as was board approved, but incentive rewards will be distributed through the end of 2023.	
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q4 (November): 30 day- 40.48 %, 7 day-17.86%; BHI real-time report Q4 : 30 day- % , 7 day- % . 1) Continued outreach to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination of interventions. Barriers encountered: Decrease in iniitial admissions but increase in member Re-admissions. Members not attending follow-up appointments due to readmission; members declining assistance from PCC or IP facility in assisting member with creating OP BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up.	1) Continue conducting post discharge outreach to members. 2) Continue tracking members and outreach for those who are not attending follow-up appointments within 7 days of discharge.	
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.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q4 (November): Initiation Phase- 42.66%, Continuation and Maintenance Phase- 48.47% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member follow/up visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Reviewing data for compliant and non-compliant providers. 4) Submited article on Treatment for Children with ADHD to educate members on ADHD which will be included in the Medi-Cal Member newsletter Spring edition 2023. 5) Distributed non-compliant provider letters.	1) Continue member outreach for those members who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters.	

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Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q4 (December): M/C: 72.71% OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis do not see their PCP regularly.	1) Continue tracking members in need of diabetes screening test. 2) Continue outreach to prescibing providers.	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q4 : 30 day- 25.07 %, 7 day- 14.58% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. On 12/7/22, BHI attended CalOptima Health Quality Forum to present on FUM and discuss with HNs their experience, barriers, opportunities for improvement. HN's did express concern regarding lack of Health Information Exchange in a timely manner.	1) Finalize FUM Tableau report to identify trends. 2) Present FUM data at the next HN Quality meeting to discuss findings. 3) Obtain real-time data from vendor and develop process to alert or notify HN's of ED visit for mental illness.	
IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 454 Processed, 404 approved, 50 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. 2) Emerging Risk Health Coach Outreach: MC 460 members, 214 Assigned, 3 No Longer Eligible, 9 No Longer Emerging Risk, 0 Opt Out, 5 Unable to Contact OC 6 members, 3 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 24 members, 13 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 1 No Longer Eligible. 3) Member Engagegment Strategy: Texting: CDC texting campaign 2,444 Medi-Cal members identified IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachble/no answer Social Media: Nov 2022-Jan 2023 ESV Total reach (the number of unique users the ad reached)=133,975 Impressions(the number of times an ad appears in all user feeds, can appear to same user more than once)= 297,851 4) Prop 56 provider value based payments for diabetes care measures.	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. 2) Completed 3-year period on 12/31/2022, will end this initiative. 3) Texting: relauch text campaign in 2023. IVR: relauch IVR campaign in 2023. Social Media: continue campaign in 2023.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 345 Processed, 305 approved, 40 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. 2) VSP Eye Exam Reminder Letters distributed on 11/15/2022 MC=7,688 OC=180 OCC=1,891 3) Member Engagegment Strategy: Texting: CDC texting campaign 2,444 Medi-Cal members identified IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachble/no answer Social Media: Nov 2022-Jan 2023 ESV Total reach (the number of unique users the ad reached)=133,975 Impressions(the number of times an ad appears in all user feeds, can appear to same user more than once)= 297,851 4) Prop 56 provider value based payments for diabetes care measures	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. 2) Continue to have VSP send Eye Exam Reminder letters to our members monthly. 3) Texting: relauch text campaign in 2023. IVR: relauch IVR campaign in 2023. Social Media: continue campaign in 2023.	

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Implement multi-disciplinary approach to improving diabetes care for CHCN Members Pilot	1) Lower HbA1c to avoid complications; 2) reduce emergency department (ED) visits and hospitalizations /readmission rates; 3) improve member and provider satisfaction; and 4) optimize diabetes medication management.	Program Design: 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement	12/31/2024	Nicki Ghazanfarpour Jocelyn Johnson Joanne Ku	QIC		X	1) The workgroup reviewed and finalized the workflow for the pilot program. 2) The workgroup continued working with ITS to build member stratification for the pilot program. 3) For provider engagement, in lieu of hosting a provider webinar, the workgroup discusssed visitng the hig volume PCP offices in-person in 2023 (once member stratification is completed) and seek their participation.	1) Finalize the member stratification list and PCP list by the end of January 2023 (dependent on ITS). 2) Finalize necessary documents/artifacts for the pilot program (e.g., scripts, one-page flyer, SharePoint scheduler, etc.). 3) Launch the pilot program by the end of Q1.	
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino Helen Syn	QIC	MC	X	1) Member Health Reward of $50 for Postpartum Care visit within 1-12 weeks after delivery is continuing. Total # of PPC health rewards approved October through December: 197. 2) Postpartum Mailing Initiative: Process for the first quality Initiative mailing is still being developed. Mailing projected to go out by end of Q1 2023. Mailing will target members that recently delivered (identified via and encourage timely postpartum care. 3) Bright Steps Program conducted initial outreach to 687 unique members. Total of 999 outreach attempts made to 635 postpartum members. 222 postpartum assessments completed. 4) Bright Steps Program received a total of 670 new Pregnancy Notification Reports and conducted outreach to engage members with the program. 5) Perinatal and Postpartum Bright Steps Program participated in 2 community events that combined resulted in outreach to 265 individuals. Collaborated with Gilbert High School in Anaheim (October 2022) to provide as part of teen pregnancy program to provide education and CalFresh + Resource event in Huntington Beach (November 2022). A combined total of 350 persons were outreached through these public events. 6) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. November 2022 Prospective Rates: Timeliness of Prenatal Care: 80.45%- Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 69.43%- Measure is performing higher than same time last year and has not met the 50th percentile.	1) Continue to expand member engagement strategy to ensure multi-modal approach to include the following elements: text campaigns, IVR robocalls, social media, member mailings etc. 2) Exploring integration of the Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care. 3) Continue to expand on provider engagement strategy to ensure PNR submission and increase Bright Steps Program Outreach.	
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 7-12 Newsletter mailing, delayed to Q1 2023 due to rebranding of newsletter - Well-Child 0-30 Months Text Message Campaigns (W30, CIS) in October: 1904 and November: 3969 members. - Well-Child 0-30 Months IVR Campaign (W30) in October: 274, and December: 4716 members. - Well-Care 12-17 Years IVR campaign (WCV 12-17) in October: 11686, and December 13854 members. - Well-Care 3-17 Years Text Message Campaigns (WCV 3-17) in October: 11577 and December: 10568 members. - In-House Live Call Campaign for LSC, CIS, W30 in October to 2391 members - In-House Live Call Campaign for W30-First 15 in November to 191 members. - In-House Live Call Campaign for WCV-18-21 Years in November-December to 3540 members. - LSC, CIS, W30 in-house call campaign for year end push (noncompliant members), completed - PBS TV Ad Campaign - Well Care Visits in December. 2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices. 4) November 2022 Prospective Rates. Note 50th percentile benchmarks have been updated. New benchmarks became available 9/30/22. CIS Combo 10: 30.93%; has not met MPL. IMA Combo 2: 44.90%; met MPL. Rate is LOWER than last year and has met 66th percentile. W30 First 15 Months: 35.91%; have not met MPL (55.72%). First year with benchmarks to monitor PR. W30 15-30 Months: 66.75%; have not met MPL (65.83%). First year with benchmarks to monitor PR. WCV: 42.34%; have not met MPL (48.93%). First year with benchmarks to monitor PR.	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2, and 7-12 Newsletter mailing in Q1 2023 - Well-Child (0-30 Months) IVR, text message, and in-house live-call campaign - Well-Care (3-17 Years) IVR and text message campaign 2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices.	

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Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in October 2022 to health networks with Q2 2022 data on members that have not been screened as recommended for blood lead screening. Launched HN attestation process for HN to attest to receiving report and additional lead operational and regulatory requirements. For CCN Providers, launched capability for attestation in December via Provider Portal. 2) Continuing member engagement strategy. Member text campaign launched on December 6 that reached 864 unique members; PBS TV campaign ad "Protect Your Child from Lead Poisoning" launched mid December; Live call campaign (In-House) to support closure of HEDIS gaps for LSC, CIS, W30 in October: 2391 members 3) Continued with provider education: conducted two blood lead CE/CME's in October; shared updates with health networks on matters related to blood lead (e.g., gap reports, HN attestation process, internal policy updates) via 1:1 quality meetings, Quality Forum, Health Network Quality Forum, CCN Virtual Meeting. 4) Updated internal policy GG.1717 to reflect HN and CCN provider requirements related to attestation requirements, documentation of blood lead refusals, etc. 5) LSC continued to be part of Pay for Value program. November 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performance level- MPL). MC: 59.95% Measure is performing higher than the same time last year. Measure has not met the 50th percentile (MPL).	1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Enhance reports to include provider summary to support HNs and CCN providers with total untested members. 2) Continuing strategy to engage and update providers of blood lead testing requirements. 3) Continue expanding member engagement strategy to include multi-modal approach via: texting, robocalls, social media. PBS TV campaign expected to continue through Q1 2023. 4) Bright Steps Program, expansion of calls to include follow-up of child members at 6 and 11 months. This follow-up is in alignment with well-child visits. Calls will provide reminders to encourage well-child visits and provide education on lead and blood lead testing recommendations for child members.	
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC	X	Q4, Provider Relations finalized the provider recruitement communication, including "No Thank You" letters, "Welcome letters" credentialing packets as required. All forms were reviewed by QI, Contracting and PDMS to ensure all providre data will be captures.	Creating packets on PDF fillable friendly forms	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC		Q4, Provider Relations will continue to conduct provider directory validations and submit to PDMS for changes	Discussion around provider directory implementation and provider portal enhancement to include automation	
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Planned Activities -Implemented •Non-compliance tracker completed and 1,800+ non-compliance letters for appointment and telephone access mailed to providers via USPS at the end of December. This year's mailing included escalation letter which includes a CAP for providers who were identified as non-compliant for a measure for three consecutive years. Providers who recieved a warning letter which is a second year notice of non-compliance, were assigned to one HN for education and follow-up. In most cases, assignment was based on where most of the provider membership was held. 2) Planned Activities -Implemented •Timely Access PDSAs issued to HNs in January 2022, were officially closed in October and email notifications sent to networks. •Based on the 2021-22 Timely Access results, the HNs struggled meeting the 80% MPL for a high percentage of the Access standards and therefore, all HNs with the exception of KP were issued a CAP in late December via email. Goal for Urgent Specialists-Met: Goal: 61.1%; 2021-22 Actual: 64%	Improving Timely Access Appointment Availability will continue to be monitored for 2023 with modifications to activities. 1) •Provider submissions to CAPs due at end of Jan. Will review and determine next steps. •Will review HNs feedback on provider outreach and education on non-compliance standards at end of Q1/early Q2. 2) HN submissions to CAPs due end of Jan. Will review and determine next steps.	

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2022 QI Work Plan Element Description	Goals	Planned Activities	**Target Date(s) for Completion**	Staff Responsible	Report to Committee	LOB	**Con't Monitoring from 2021**	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 in 2023** (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Red - Did not Meet Goal Green - Met Goal
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Provider Relations conducted provider directory validations through calendar year with a total of 97% completion rate. All updates/changes were submitted to PDMS for data updates. 2) Non-compliance tracker completed and 1,800+ non-compliance letters for appointment and telephone access mailed to providers via USPS at the end of December. Assigned HN to outreach and provide education to those who recieved a warning "2nd" year letter. No Live Contacts After 3 Attempts: 27.5% (not met)	1)Provider Relations will maintain process for directory validation and update customizing validation template on provider portal. Work request submitted to ITS and Provider Portal Workgroup. 2)Improving telephone access will continue to be monitored in 2023 with minor modifications to activities •Provider submissions to CAPs due at end of Jan. Will review and determine next steps. •Will review HNs feedback on provider outreach and education on non-compliance standards at end of Q1/early Q2.	
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: Medi-Cal Plan Level: •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met Medi-Cal HN Level: •Mandatory Provider Types: Met •Provider to Member Ratios: -PCPs: Met for all HNs -Specialists: Not Met (Arta, Monarch) •Time/Distance: Not Met Medi-Cal Timely Access •Timely Access PDSAs (issued Jan-2022) were reviewed and closed out. Official email sent to networks October 27th. •HNs were provided a quarterly Subcontract Network Certification Summary report with their network adequacy performance for November. •Provided HN with DHCS Provider List to help close the providers gaps for time/distance and MPT standards.	Throughout the year, CalOptima consistently met Net-Adequacy standards at the Plan level. Continue to monitor and notify HNs of areas of non-compliance.	
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (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 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Kelly Giardina	QIC	MC, OC,OCC	X	1) The CORE report has been updated to include Medi-Cal LOB. 2) PCP Discharge letter was updated to include this language: "Please verify that this member is scheduled with your office for discharge follow up care." "CalOptima Health is dedicated to preventing re-admissions and request your assistance with facilitating the scheduling of this important appointment. We request this member be seen by his/her PCP within 1-3 days of discharge." The member unable to contact (UTC) letter has also been updated but is not programmed into the system yet. There was also a memo drafted by CM for the hospitals, and it was sent to the consultant for review. 3) Launched the pilot ED/Facility Rounds programs.	Continue meetings to discuss open items and data analysis to shift approach as needed. Finalize the communication (provider memo) to hospitals based on the consultant's recommendation.	

20232

QUALITY IMPROVEMENT PROGRAM


ACCREDITED
NCQA
HEALTH PLAN
ACCREDITED

2023 QUALITY IMPROVEMENT PROGRAM

SIGNATURE PAGE~~QUALITY IMPROVEMENT PROGRAM~~

~~SIGNATURE PAGE~~

~~*Quality Improvement Committee Chair:*~~

~~*Richard Pitts, D.O., Ph.D. Date*~~
~~*Chief Medical Officer*~~

~~*Board of Directors' Quality Assurance Committee Chair:*~~

~~*Trieu Tran, M.D. Date*~~

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~~Board of Directors Chair:~~

~~Supervisor Andrew Do Date~~

Quality Improvement Committee Chair:

Richard Pitts, D.O., Ph.D. Date
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Trieu Tran, M.D., Ph.D. Date

Board of Directors Chair:

Clayton M. Corwin Date
Acting Chair

~~**Supervisor Andrew Do Date**~~

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Abbreviations

~~s With/Health Is - Committee for &ProviderService Plan~~

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Event
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems survey
	CAP	Corrective Action Plan
	CBAS	Community-Based Adult Services centers
	CCN	CalOptima Health Community Network
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COPD	Chronic Obstructive Pulmonary Disease
	COO	Chief Operating Officer
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	California Department of Health Care Services
	DMHC	California Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ED PHM	Executive Director, Population Health Management
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs
	~~ED PA~~	~~Executive Director, Public Affairs~~
	ED NO	Executive Director, Network Operations

	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream and Related Entities
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individualized Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long--Term Care
	LTSS	Long--Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Medical Doctor
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National ~~Coalition of~~Committee f~~r~~or Quality Assurance
	NET	Network
	NF	Nursing Facilities
O		
	OC	Orange County
	OCC	OneCare Connect
	OCHCA or HCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIC	Quality Improvement Committee
	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy ~~and~~& Therapeutics Committee
	PAC	Provider Advisory Committee

	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCP	Primary Care ~~Physician~~Provider
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician/Hospital Consortia
	PIP	Performance Improvement Project
	PPC	Personal Care Coordinator
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Determinants of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared-Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third-Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision ~~Services Program~~Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

~~We Are CalOptima~~CalOptima CalOptima Health Overview

Caring for the people of Orange County has been ~~CalOptima~~CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. ~~CalOptima~~CalOptima Health 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~~serve member health with excellence and dignity, respecting the value and needs of each person.

~~**The mission of CalOptima~~CalOptima Health… 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~~By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

~~Our Values – CalOptimaCalOptima Health 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~~CalOptima Health's Board of Directors and executive team worked together to develop our ~~next three-year~~2022~~3~~–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in ~~December 2019~~June 2022.~~. 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 CalOptimaCalOptima Health.~~ Our core strategy is the "inter-agency" co-

creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- ~~Innovate and Be Proactive~~Organizational and Leadership Development
- ~~Expand CalOptima~~~~CalOptima Health~~~~'s Member-Centric Focus~~Overcoming Health Disparities
- ~~Strengthen Community Partnerships~~Finance and Resource Allocation
- ~~Increase Value and Improve Care Delivery~~Accountabilities and Results Tracking
- ~~Enhance Operational Excellence and Efficiency~~Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare ~~and~~& Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underser~~vice~~ved and under-resourced communities.

Quality Mission: A~~a~~ll ~~persons~~people receive equitable, high--quality and value-based ~~care~~care.

Quality Vision: A~~a~~s a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable, and accessible care for all.

CMS National Quality Strategy Goals:

1. Embed Quality into the Care Journey: Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.
2. Advance Health Equity: Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.
3. Promote Safety: Prevent harm or death from health care errors.
4. Foster Engagement: Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.
5. Strengthen Resilience: Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.
6. Embrace the Digital Age: Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations, and individuals through interoperable, shared, and standardized digital data across the care continuum.
7. Incentivize Innovation & Technology: Accelerate innovation in care delivery and incorporate technology enhancements (e.g., telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.
8. Increase Alignment: Develop a coordinated approach to align performance metrics, programs, policy, and payment across CMS, federal partners, and external stakeholders to improve value. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers, and payers.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 ~~Draft~~ CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and stress DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

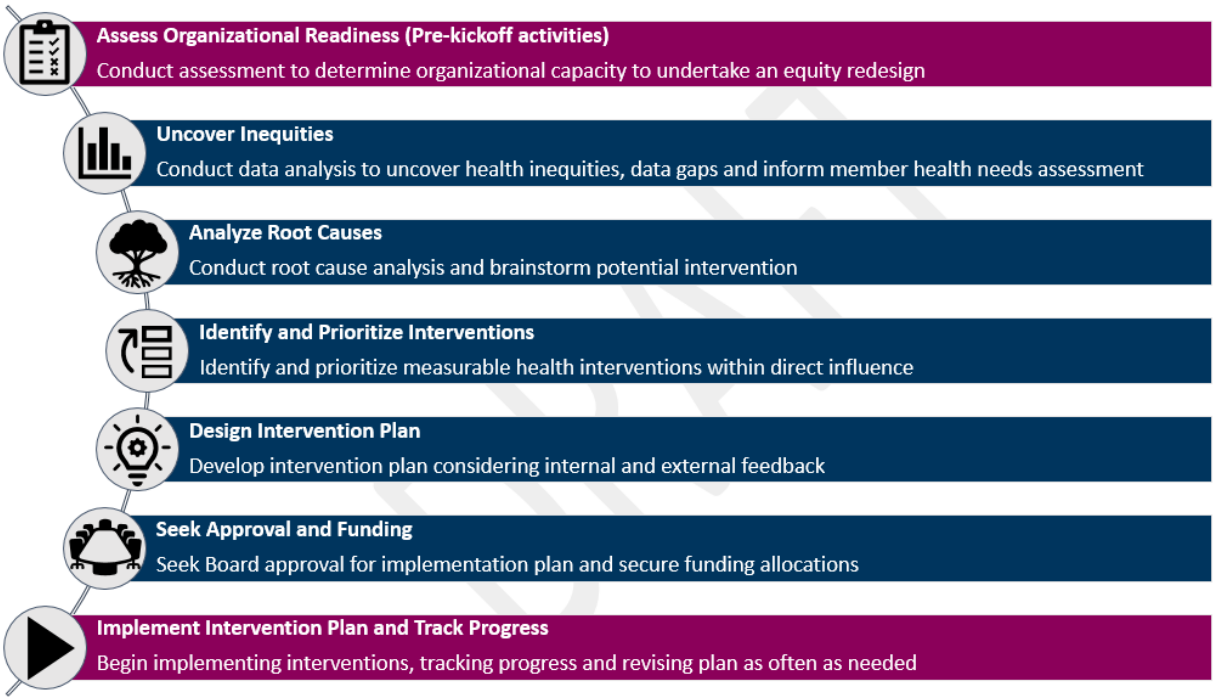
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

Social Determinants of Health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.



Comprehensive Community Cancer Screening and Support Program

~~What Is CalOptima~~CalOptima Health?

CalOptima Health strives to be the health care exemplar for all Orange County ~~(OC)~~ residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon~~,~~ and lung cancer in certain smokers. In other words:

- With rare exception, no one should die from breast cancer~~.~~
- With rare exception, no one should die from cancer of the cervix~~.~~
- With rare exception, no one should die from cancer of the colon
- With rare exception, no one should die from lung cancer in certain heavy smokers~~.~~

~~With rare exception, no one should die from lung cancer in certain heavy smokers.~~

~~Our Unique Dual Role~~

~~CalOptima~~CalOptima Health is unusual in that it is both a public agency and a community health plan.

~~As both, CalOptima~~CalOptima Health 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~~

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- ~~ENSURE TRANSPARENCY IN OUR GOVERNANCE PROCEDURES, INCLUDING PROVIDING OPPORTUNITIES FOR STAKEHOLDER INPUT~~
- ~~BE ACCOUNTABLE FOR THE DECISIONS WE MAKE~~

CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared ~~to~~with many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima Health intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community's daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners towards ~~s~~ a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have
-equitable access to high quality care. The ~~P~~program will use a phased-in approach to invest over the next five years ~~toward~~in the following three pillars:

1) Increasing community and member awareness and engagement~~;~~
2) Increasing access to cancer screening~~; and~~
3) Improving member experience throughout cancer treatment~~.~~

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these ~~casecares~~cases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer~~,~~ and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment~~1~~. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast~~,~~ or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, -ultimately increasing life expectancy, quality of life~~,~~ and reducing health care costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15% ~~percent~~, compared ~~to~~with a ~~90 percent~~90% survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix~~,~~ or colon~~2.~~ Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent ~~ten~~10-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the [1]second leading cause of cancer-related deaths following lung cancer[1].

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address

[1] https://www.science.org/doi/10.1126/science.abd3377

disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to ~~CalOptima Health's~~ members. For many years, CalOptima Health has been providing quality incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. CalOptima Health has established a Hospital Quality Program for it~~'~~s contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures ~~would~~ serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission~~;~~
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts~~;~~
- Recognize hospitals demonstrating quality performance~~;~~
- Provide comparative information on CalOptima Health hospital performance~~; and~~
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members~~.~~

The program launches January 1, 2023, and extends through December 31, 2027. ~~-~~It ~~is comprised of two (2)~~ includes two initiatives:~~-~~ Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
    a. CMS Quality~~;~~
    b. CMS Patient Experience~~;~~
    c. Leapfrog Hospital and Surgery Center Rating~~; and~~
    d. Leapfrog Hospital Safety Grade~~.~~
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
    a. Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare~~;~~
    b. Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating~~;~~ ~~and~~
    c. Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital ~~and~~
    d. Surgery Center Rating will not qualify for incentive payments~~.~~
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a ~~five (5)~~five-year period from 2023~~-~~2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based

on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared ~~to~~with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

CalOptima Health Programs

- "Better. Together." is ~~our~~CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through ~~four~~three major programs:

~~What We Offer~~

~~CalOptima Health Programs~~

Medi-Cal

~~In California, Medicaid is known as Medi-Cal. CalOptima~~CalOptima Health ~~marked 25 years of service to Orange County's Medi-Cal population in 2020.~~

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~~CalOptima Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, ~~CalOptima~~CalOptima Health 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~~CalOptima Health through the Whole-Child Model (WCM) Program that went into effect in 2019.

CalOptima Health provides ~~e~~Enhanced ~~c~~Care ~~m~~Management and ~~c~~Community ~~s~~Supports services to address social drivers of health. In 2023, we expand our ~~c~~Community ~~s~~Supports services ~~from four~~4 to ~~all~~the 14 options listed below:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Certain services are not covered by ~~CalOptima~~CalOptima Health 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 the Medi-Cal Dental 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~~CalOptima Health has developed specialized ~~case~~care management services. These ~~case~~care 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~~CalOptima Health 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~~ In July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for ~~CalOptima~~CalOptima Health Medi-Cal members. ~~CalOptima~~CalOptima Health 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)

CalOptima Health 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. The 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 Health 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 Health 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 people with disabilities. CalOptima Health 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 Health LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

~~**Emergency Department Diversion Pilot**~~

OneCare (HMO D-SNP)

Our OneCare ~~(OC)~~ members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for ~~our members~~them to get the health care they need. Since 2005, ~~CalOptima~~CalOptima Health has been offering ~~OC~~ OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. ~~OC~~ OneCare has extensive experience serving the complex needs of the frail, disabled, ~~dual~~ 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.~~

~~OneCare provides a comprehensive scope of services for dual~~ dual ~~eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures including Part C, Part D, and CMS sStar measures.~~

To be a member of ~~OC~~OneCare, a person must live in Orange County and ~~not be eligible for OCC~~be eligible for both Medicare and Medi-Cal. Enrollment in ~~OC~~ OneCare is voluntary and by member choice.

Scope of Services

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures including Part C, Part D, and CMS ~~star~~ Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, ~~CalOptima~~CalOptima Health ~~OC~~OneCare members are eligible for enhanced services, such as gym memberships.

~~OneCare Connect~~

~~The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) 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.~~

~~OneCare Connect achieves these advancements via CalOptima~~CalOptima Health~~'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 individualized health care plans that fit 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.

The Cal MediConnect demonstration program is ending in 2022, and CalOptimaCalOptima Health is planning to transition OCC members to OC, effective January 1, 2023.

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 and over-the-counter benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

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 2022 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.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have 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 September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths, but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptimaCalOptima Health identified opportunities to improve health equity as part of the QI Work Plan.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to 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 combines health care and adult day care for people with multiple chronic conditions. These can be offered in yourthe member's home, in the community or at the CalOptima Health our PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program

Hospital care and emergency servicesADD DESCRIPTION

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and stress DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

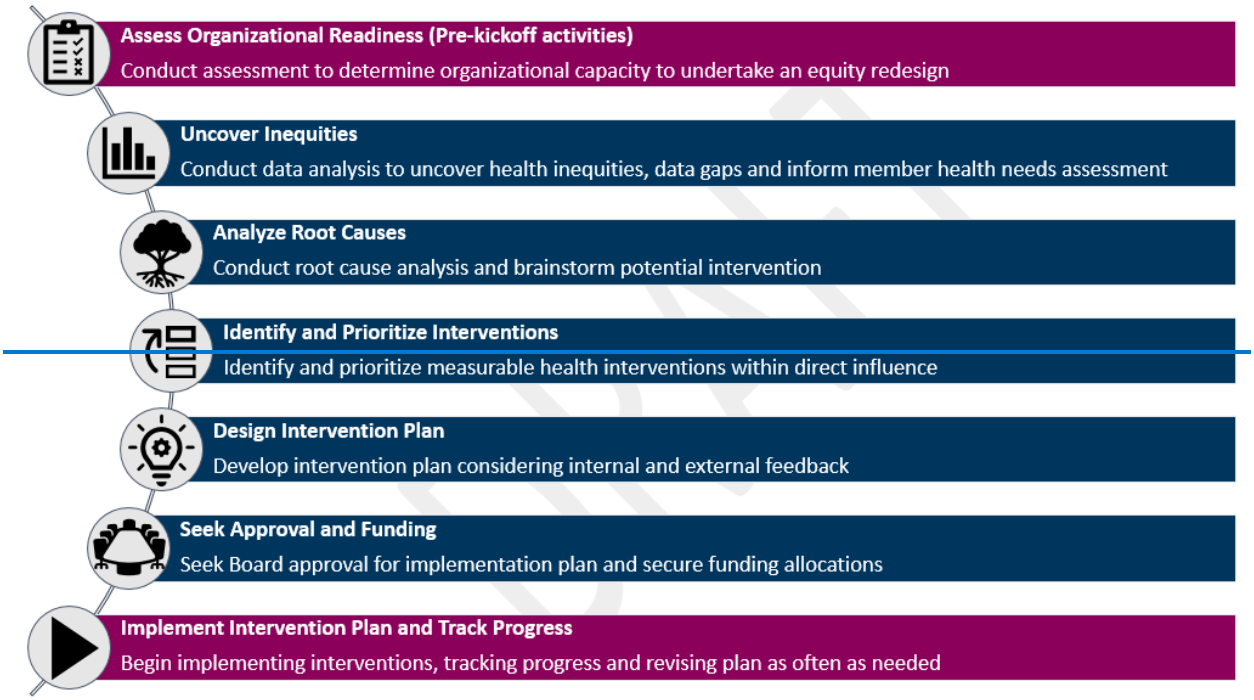
Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of

social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

Social Determinants of Health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptimaCalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.



California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptimaCalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits and discharge delays.

CalOptimaCalOptima Health's implementation of ECM and Community Supports build upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptimaCalOptima Health's HHP Community-Based Care Management Entities will transition to become ECM Providers. This means that CalOptimaCalOptima Health and our delegated health networks (HNs) will provide ECM services as ECM providers to eligible populations. These providers will be responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

Beginning January 1, 2022, ECM went live for the following populations of focus:

- Members experiencing homelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)

Additionally, members participating in WPC and/or HHP automatically transitioned into ECM.

HHP and WPC service providers will continue to provide services under Community Supports as CalOptimaCalOptima Health works to expand the network of Community Supports providers that have the expertise and capacity to provide the specific types of services. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services

7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Beginning January 1, 2022, CalOptimaCalOptima Health offers the following four Community Supports services:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Recuperative care (medical respite)

CalOptimaCalOptima Health will continue to assess the needs the of members and collaborate with community stakeholders to add new Community Supports.

2021–22 CalOptimaCalOptima Health Community Network (CCN) Pilot Program

Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members With Poorly Controlled Diabetics

To address high rates of poorly controlled diabetics identified in the CCN network, the following pilot program was proposed and approved by the CalOptimaCalOptima Health Board of Directors.

1. Pharmacist Involvement and Intervention:
   CalOptimaCalOptima Health pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptimaCalOptima Health believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with primary care providers (PCPs) and health coaches/registered dietitians/case managers.
2. Health Coach/Registered Dietitian Management Intervention:
   CalOptimaCalOptima Health health coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials and referral to other community resources based on needs. Health coaches/registered dietitians will also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.
3. Non-Monetary Member Incentives:
   CalOptimaCalOptima Health would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives:
   In order to have successful provider support, CalOptimaCalOptima Health proposes providing incentives for their dedicated participation in this multidisciplinary diabetes program. Providers are eligible for incentives when they manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

~~Pharmacy Administration Changes~~

~~Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptimaCalOptima Health-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 Medi-Cal only and does not affect OC, OCC or PACE.~~

8.

OneCare Connect

On January 1, 2023, ~~the~~ CalOptima Health's OneCare Connect plan ~~program sunset~~ended~~t as a CalOptima Health Program~~. ~~Members in this program~~ were transitioned to OneCare.

~~With Whom We Work~~ CalOptima Health Provider Partners

~~Contracted Health Networks/Contracted Network Providers~~

Providers have options for participating in ~~CalOptima~~CalOptima Health's programs to provide health care to ~~CalOptima~~CalOptima Health members. Providers can contract through ~~CalOptima~~CalOptima Health Direct, ~~CalOptima~~CalOptima Health Direct-Administrative and/or ~~CalOptima~~CalOptima Health Community Network (CCN) and/or contract with a ~~CalOptima~~CalOptima Health ~~Health~~ Network (HN). ~~CalOptima~~CalOptima Health members can choose CCN or one of 12 HNs representing more than 9,400 ~~practitioners~~providers.

~~CalOptima~~CalOptima Health Direct (COD)

~~CalOptima~~CalOptima Health Direct has two elements: ~~CalOptima~~CalOptima Health Direct-Administrative and CCN.

- ~~CalOptima~~CalOptima Health Direct-Administrative (COD-A)

  ~~CalOptima~~CalOptima Health Direct-Administrative is a self-directed program administered by ~~CalOptima~~CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in ~~OC~~OneCare ~~or OCC~~), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

- ~~CalOptima~~CalOptima Health Community Network (CCN)

CCN doctors ~~with an~~have an alternate path to contract directly with ~~CalOptima~~CalOptima Health to serve our members. CCN is administered directly by ~~CalOptima~~CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

~~CalOptima~~CalOptima Health Contracted Health Networks

~~CalOptima~~CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group~~s~~ (SRG)

Through our delegated HNs, ~~CalOptima~~CalOptima Health members have access to more than 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 long-term care facilities.

~~CalOptima~~CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Health Network	PHC	-
AMVI/Prospect Medical Group	-	SRG
CHOC Health Alliance	PHC	-
Family Choice Medical Group	PHC	SRG
HPN-Regal Medical Group	HMO	-
Kaiser Permanente	HMO	-
Noble Mid-Orange County	SRG	SRG
Optum Care Network - Arta	SRG	SRG
Optum Care Network - Monarch	HMO	SRG

Optum Care Network - Talbert	SRG	SRG
Prospect Medical Group	HMO	-
United Care Medical Group	SRG	SRG
Delegated Vendor	**Medi-Cal**	**OneCare**
Vision Service Plan	VS	VS
MedImpact		PBM

HMO=Health Maintenance Organization
PHC=Physician-/Hospital Consortium
SRG=Shared Risk Group
VS=Vision Service
PBM-=-Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, ~~the HNs~~ contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex ~~case~~care management
- Claims
- Contracting
- Credentialing of practitioners
- Customer service

Membership Demographics

Membership Data* (as of October 31, 2022)

Total CalOptima Health Membership	Program	Members
937,584	Medi-Cal	919,992
	~~OneCare Connect~~	~~14,198~~
	OneCare (HMO D-SNP)	2,964
	Program of All-Inclusive Care for the Elderly (PACE)	430

*Based on unaudited financial report and includes prior period adjustment

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership	Program	Members
944,975	Medi-Cal	927,086
	OneCare Connect	14,385
	OneCare (HMO D-SNP)	3,067
	Program of All-Inclusive Care for the Elderly (PACE)	437

*Based on unaudited financial reports and includes prior period adjustment. Data from prior to the OneCare Connect program end on January 1, 2023.

Member Age	
0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference	
English	58%
Spanish	27%
Vietnamese	10%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Member Demographics (as of December 31, 2022)

Member Age	
0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2022

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

Membership Data from December 31, 2021, Financial Information

Total CalOptima Membership
870,489

Program	Members
Medi-Cal*	852,805
OneCare Connect	14,933
OneCare (HMO SNP)	2,330
Program of All-Inclusive Care for the Elderly (PACE)	421

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)		Languages Spoken (All Programs)		Medi-Cal Aid Categories	
9%	0 to 5	59%	English	41%	Temporary Assistance for Needy Families
27%	6 to 18	26%	Spanish	35%	Expansion
33%	19 to 44	10%	Vietnamese	9%	Optional Targeted Low-Income Children
19%	45 to 64	2%	Other	9%	Seniors
12%	65+	1%	Korean	5%	People with Disabilities
		1%	Farsi	<1%	Long-Term Care
		<1%	Chinese	<1%	Other
		<1%	Arabic		

Financial Information FY 2021–22 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	$3,249,878,660	88.89%
OneCare Connect	$339,332,450	9.28%
OneCare	$25,409,771	0.69%
PACE	$40,274,039	1.10%
MSSP**	$1,218,536	0.03%

Note: Fiscal Year 2021–22 Operating Budget began on July 1, 2021.
** Multipurpose Senior Services Program (MSSP)

Total Budgeted Annual Revenue
$3.7 billion

CalOptima spends nearly 96 cents of every dollar on member care.

Quality Improvement Program

~~CalOptima~~CalOptima Health's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and ~~customer~~ quality of 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~~CalOptima Health 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 subacute care to 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, special health care needs~~,~~ and chronic illnesses.

~~CalOptima~~CalOptima Health's Quality Improvement 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 or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

~~CalOptima~~CalOptima Health is committed to promoting diversity in practices throughout the organization, including HR best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias~~,~~ and inclusion.

Quality Improvement Program Purpose

The purpose of the ~~CalOptima~~CalOptima Health QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to ~~CalOptima~~CalOptima Health members through ~~CalOptima~~CalOptima Health CCN and COD-A, as well as our contracted HNs. Through the QI Program — and in collaboration with providers and community partners — ~~CalOptima~~CalOptima Health strives to continuously improve the structure, processes~~,~~ and outcomes of ~~its~~ the health care delivery system to serve our members.

The ~~CalOptima~~CalOptima Health QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of ~~CalOptima~~CalOptima Health'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~~CalOptima Health'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 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 to ~~the public health authority (~~OCHCA ~~)~~ outbreaks of conditions and/or diseases, which may include~~,~~ but are not limited to~~,~~ methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, ~~etc.~~and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of 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~~CalOptima Health.

- Ensure the annual review and acceptance of the UM Program Description, Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member centric Population Health Management (PHM Program.

In collaboration with the Compliance Audit & Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by ~~CalOptima~~CalOptima Health's contracted HNs, including CCN and/or COD network providers serving ~~CalOptima~~CalOptima Health's various populations:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively~~,~~ and efficiently.

- Continuously improve 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 I~~identify in a timely manner the important clinical and service issues facing the Medi-Cal and~~,~~ ~~OC~~OneCare ~~and OCC~~ populations relevant to their demographics, high risks, disease profiles for both acute and chronic illnesses, and preventive care.

- Ensure 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.

- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.

- ~~-~~Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.

- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.

- Ensure the reliability of risk prevention and risk management processes.

- Ensure compliance with regulatory agencies and accreditation standards.

- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with ~~CalOptima~~CalOptima Health's strategic direction in support of its mission, vision and values
- Ensure 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~~CalOptima Health 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~~CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to ~~CalOptima~~CalOptima Health 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~~CalOptima Health's state and federal contracts — and to ~~CalOptima~~CalOptima Health'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~~CalOptima Health 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~~CalOptima Health'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
4.

Member Advisory Committee

The Member Advisory Committee (MAC) has 15 voting members, with each seat representing a constituency served by ~~CalOptima~~CalOptima Health. The MAC ensures that ~~CalOptima~~CalOptima Health 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 ~~monthly~~ bimonthly basis and reports directly to the ~~CalOptima~~CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- ~~HCA~~
- ~~LTSS~~
- Medi-Cal beneficiaries
- ~~Medical safety net~~
- Member Advocate
- County of Orange Social Services Agency (OC SSA)

- OneCare Member (2 seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

~~Two~~One of the 15 positions — held by ~~HCA and~~ OC SSA — ~~are~~ is a standing seat ~~permanent~~. Each of the remaining 1~~4~~3 appointed members may serve ~~two~~two consecutive three-year terms ~~with no term limits~~.

~~OneCare Connect Member Advisory Committee~~

~~The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptimaCalOptima Health Board of Directors. The OCC MAC has 10 voting members, each seat representing a~~

~~constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the program.~~

~~The OCC MAC membership includes 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~~

~~In-Home Supportive Services (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 bimonthly meetings are open to the public.~~

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the ~~CalOptima~~CalOptima Health Board of Directors to advise the Board on issues impacting the ~~CalOptima~~CalOptima Health provider community. The PAC members represent the broad provider community that serves ~~CalOptima~~CalOptima Health 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 monthly and is~~meetings are 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
- Safety net
- 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~~CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

- Family representatives (seven seats)
  - Authorized representatives, which includes parents, foster parents and caregivers of a ~~CalOptima~~CalOptima Health member who is a current recipient of CCS services; or
  - ~~CalOptima~~CalOptima Health members age 18–21 who are current recipients of CCS services; or
  - Current ~~CalOptima~~CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (four seats)
  - Community-based organizations; or
  - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC ~~meets bimonthly, and~~ quarterly meetings are open to the public.

~~Role of CalOptima~~CalOptima Health Officers' Role ~~for~~ in the Quality Improvement Program

~~Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 (c). On-going monitoring is performed to ensure that no medical director is listed on state or federal exclusion or preclusion lists.~~

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 Customer Service, Information Technology Services, Enterprise Prog~~ra~~ject Management Office~~m Implementation, Process Excellence~~, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, ~~,~~ Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health'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.

~~**Chief Information Officer** (CIO) provides oversight of CalOptimaCalOptima Health's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.~~

~~**Chief Operating Officer** (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Program Implementation, Process Excellence, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, and Coding Initiatives.~~
Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The ~~ED C~~CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the ~~ED C~~CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima. ~~EThe CHRO e~~The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

~~**Chief Medical Officer** (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptimaCalOptima Health'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~~CalOptima Health's medical care delivery system. The DCMO collaborates with ~~directors~~ Directors and ~~medical~~ Medical D~~d~~irectors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, ~~Case~~Care Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support ~~CalOptima~~CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

Medical Director* (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The ~~medical~~ Medical ~~director~~ Director provides direction and support to ~~CalOptima~~CalOptima Health's Quality ~~and Population Health Management~~ teams to ensure QI Program objectives are met. ~~The medical director is also the physician designee who chairs the Credentialing Peer Review Committee (CPRC)~~.

Medical Director* (Behavioral Health) is the designated behavioral health care physician 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~~ Medical ~~director~~ Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Executive Director, Quality ~~& Population Health Management~~ (ED Q~~&PHM~~I) 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 NCQA accreditation standing as a high performing health plan. The ED QI~~&PHM~~ serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI~~&PHM~~ are the ~~directors~~ Directors of Quality Analytics, Quality Improvement~~,~~ and ~~Population Health Management~~Credentialing.

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide ~~Population Health Management~~PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM. ~~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 NCQA accreditation standing as a high performing health plan. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED Q&PHM are the directors of Quality Analytics, Quality Improvement and Population Health Management.~~

Executive Director, Behavioral Health ~~Integration Initiative~~Integration (ED BHI) is responsible for oversight of ~~CalOptima~~CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

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~~Care 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 ~~Q&~~PHM, makes certain that Medical Affairs is aligned with ~~CalOptima~~CalOptima Health's strategic and operational priorities.

Executive Director, ~~Program Implementation~~Medicare Programs (ED ~~PI~~MP) 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 is the director of Process Excellence.~~ strategic and operational oversight of Medicare programs including OneCare and PACE.

~~**Executive Director, Public Affairs** (ED PA) is responsible for CalOptima~~CalOptima Health~~'s Communications, Government Affairs, Community Relations and Strategic Development departments. ED PA is charged with assisting the CEO in carrying out organizational goals, including overseeing the development of the CalOptima~~CalOptima Health~~ Strategic Plan and implementation of communications strategies to highlight CalOptima~~CalOptima Health~~ programs and priorities. Under ED PA's leadership, the Public Affairs team members collaborate on efforts that support the CalOptima~~CalOptima Health~~ mission and reach internal and external audiences, ranging from employees and members to government officials and the media. Reporting to ED PA are the directors of both Communications and Strategic Development.~~

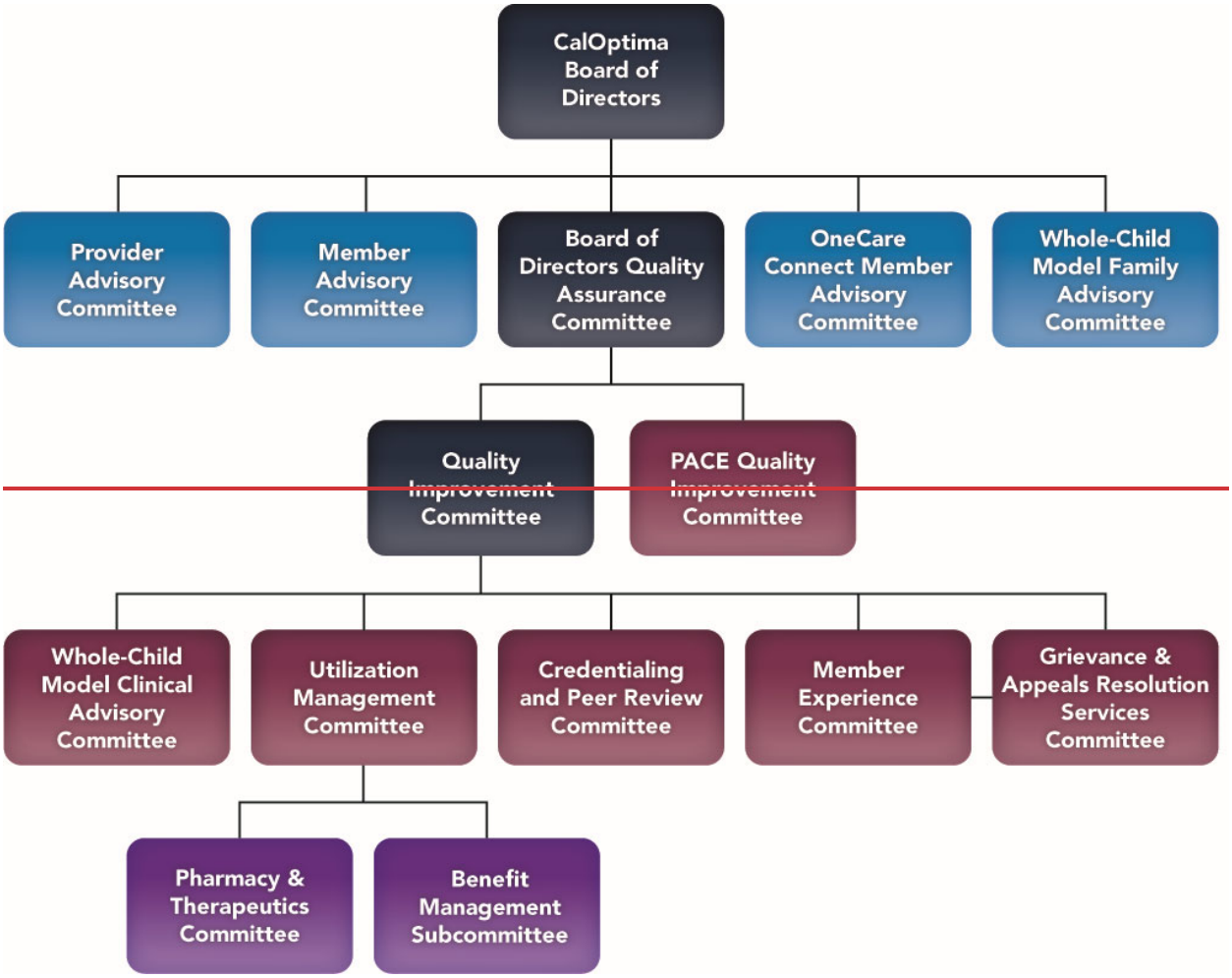
~~**Executive Director, Compliance** (ED C) is responsible for monitoring and driving interventions so that CalOptima~~CalOptima Health~~ and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential 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~~CalOptima Health~~'s regulatory and compliance functions, including the development and amendment of CalOptima~~CalOptima Health~~'s policies and procedures to ensure adherence to state and federal requirements.~~

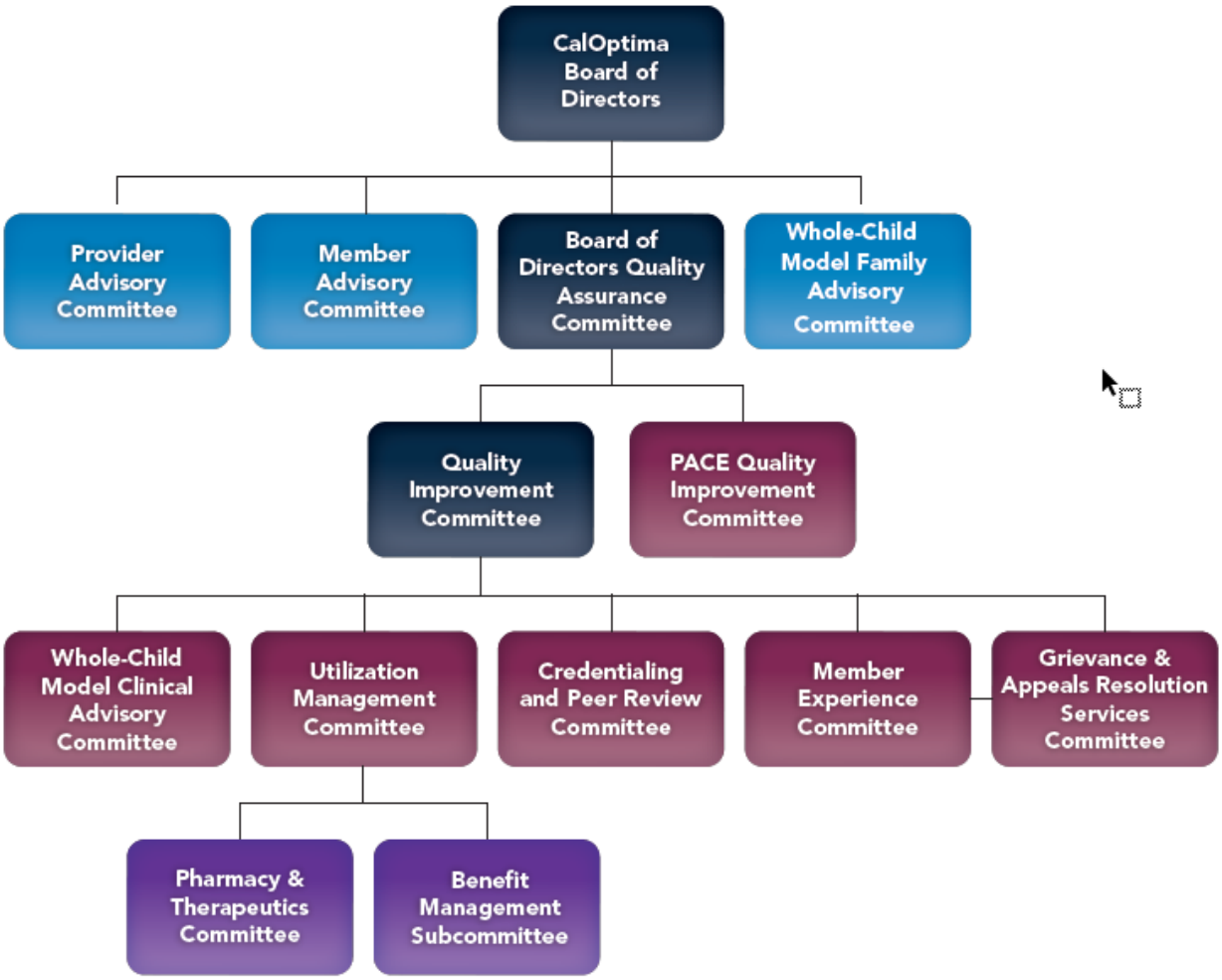
Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve ~~CalOptima~~CalOptima Health's networks and making sure the delivery of accessible, cost-effective and 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.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 (c). ~~On-going~~ Ongoing monitoring is performed to ensure that no ~~medical~~ Medical ~~director~~ Director is listed on state or federal exclusion or preclusion lists.

Committee Organization Structure – Diagram


CalOptima Board of Directors
Provider Advisory Committee
Member Advisory Committee
Board of Directors Quality Assurance Committee
OneCare Connect Member Advisory Committee
Whole-Child Model Family Advisory Committee
Quality Improvement Committee
PACE Quality Improvement Committee
Whole-Child Model Clinical Advisory Committee
Utilization Management Committee
Credentialing and Peer Review Committee
Member Experience Committee
Grievance & Appeals Resolution Services Committee
Pharmacy & Therapeutics Committee
Benefit Management Subcommittee



Quality Improvement Committees aAnd 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 HNs 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 delegated HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to ~~CalOptima~~CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, ~~ease~~care 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~~CalOptima Health'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 QIC ~~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~~.~~;
- Monitor~~s~~ing overall quality compliance for the organization to quickly resolve deficiencies that affect members~~.~~

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with ~~applied behavioral analysis~~Applied Behavior Analysis utilization. Recommendations are made to promote practices so that all members receive medical and behavioral health care that meets ~~CalOptima~~CalOptima Health standards.

The QIC oversees and coordinates member outcome-related ~~quality improvement~~QI 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~~CalOptima Health-contracted providers and practitioners, and delegated HNs.

~~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~~ charter and includes~~, but may not be limited~~ but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- ~~CalOptima~~CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- ~~CalOptima~~CalOptima Health Medical Directors
- CalOptima Health Quality Improvement Medical Director~~s~~
- ~~CalOptima~~CalOptima Health Behavioral Health Integration Medical Director (or Designee)
- CalOptima Health Executive Director, ~~,~~ Quality ~~& Population Health Management~~
- CalOptima Health Executive Director, ~~,~~ Population Health Management
- CalOptima Health
- Executive Director, ~~,~~ Clinical Operations
- CalOptima Health Executive Director, ~~,~~ Network Management
- CalOptima Health Executive Director, ~~,~~ Operations

The QIC is supported by CalOptima Health departments including but not limited to ~~the following~~:~~:~~

- ~~Director, Quality Improvement~~
- ~~Director, Quality Analytics~~
- ~~Director, Population Health Management~~
- ~~Director,~~ Behavioral Health Integration
- ~~Case~~Care Management
- Long ~~-~~ Term ~~Care~~Services and Supports
- Population Health Management
- Quality Analytics
- Quality Improvement
- Utilization Management
- ~~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 or participation by video conference.

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 QIC 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 QIC ~~C~~charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate ~~Quality Management/Improvement~~QI information to network providers and practitioners
- Tracking of QI Work P~~P~~lan 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.

The QIC provides to the QAC quarterly written progress reports of the QIC that describes actions taken, process in meetings QI Program objectives, and improvements made.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the ~~CalOptima~~CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve ~~CalOptima~~CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all ~~CalOptima~~CalOptima Health 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~~CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the ~~CalOptima~~CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and ~~representation of active~~ physician representatives~~s~~ from CCN and HNs. Physician participants represent a range of practitioners and specialties from ~~CalOptima~~CalOptima Health'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~~BH and LTSS services for CCN and ~~through the~~ delegated HNs to identify areas of underutilization 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 M~~m~~edical D~~d~~irector, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all ~~CalOptima~~CalOptima Health members. It 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 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~~CalOptima Health~~'s~~ members. The P&T includes practicing physicians (including both ~~CalOptima~~CalOptima Health 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 provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T 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~~CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal ~~CalOptima~~CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance 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~~CalOptima Health'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 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~~CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC 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~~CalOptima Health. 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, and the committee's focus is to improve customer satisfaction. The MEMX committee ~~is designed to assess~~assesses information and data directly from members, which include the annual results of ~~CalOptima~~CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and member complaints, grievances~~,~~ and appeals. Then MEMX ~~and~~ identifies~~y~~ opportunities ~~and~~to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, ~~who~~which report to the MEMX committee, ~~:~~monitor a member's ability get needed care and get care quickly, by monitoring the provider network, ~~including access and availability;~~ reviewing customer service metrics~~;~~, and evaluating~~e complaints, grievances, appeals,~~ authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2023~~2~~, the MEMX committee, which includes the Access and Availability ~~workgroups~~Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2022 and MY 2023 CAHPS survey results ~~and meet regulatory requirements related to access.~~ ~~.~~

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of ~~CalOptima~~CalOptima Health 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~~CalOptima Health 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.

Confidentiality

~~CalOptima~~CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all ~~CalOptima~~CalOptima Health 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.

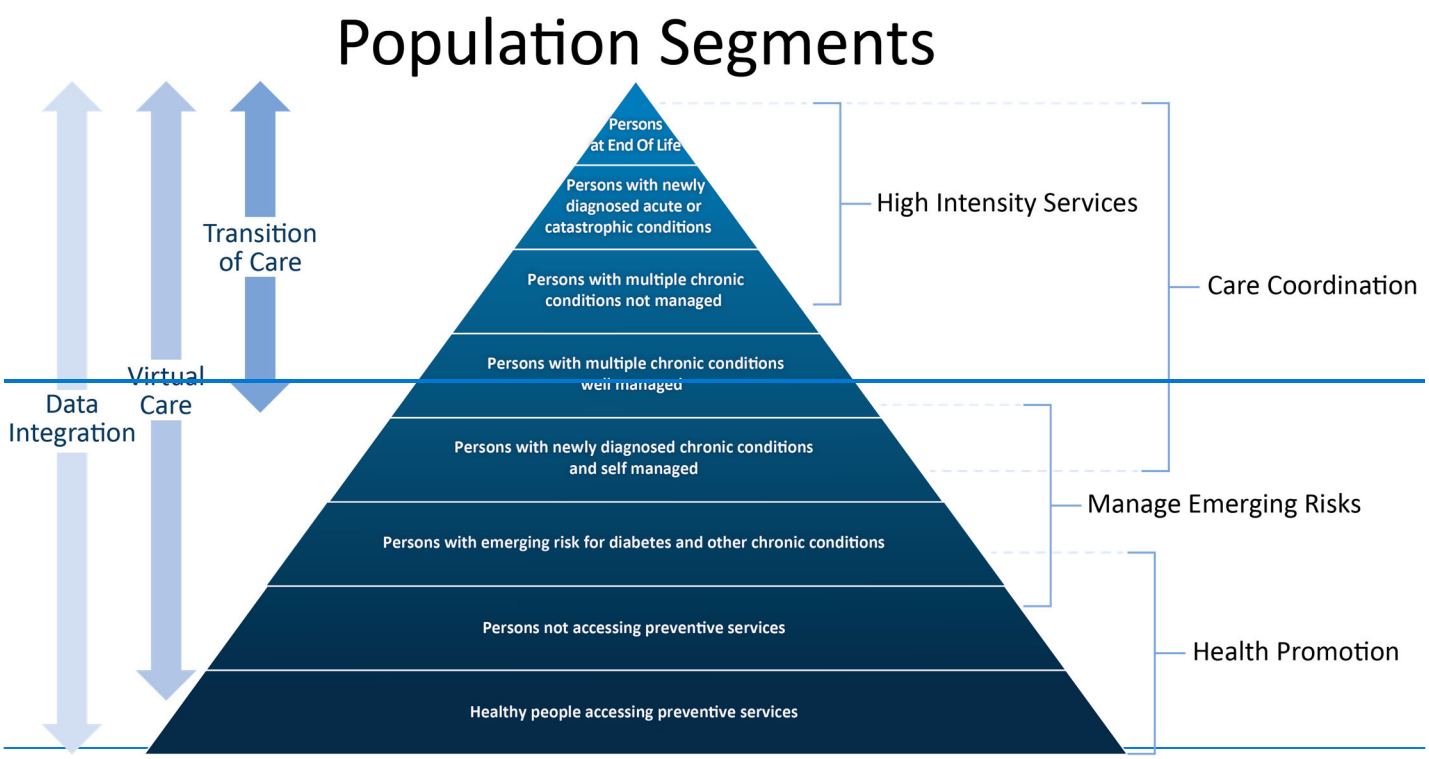
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, 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~~CalOptima Health 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~~CalOptima Health 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~~CalOptima Health~~'s existing innovative Model of Care (MOC), the 2022 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~~CalOptima Health~~'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 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.~~

~~2022~~ 2023 QI Goals and Objectives

~~CalOptima~~CalOptima Health's QI Goals and Objectives are aligned with ~~CalOptima~~CalOptima Health's 2022–~~23~~ 25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational~~,~~ and community levels.
~~2) Ensure member's safety during COVID-19 pandemic by aiming for 80% COVID-19 vaccine rate or community immunity~~
~~3)~~ Improve quality of care and member experience by ~~maintaining~~ attaining an NCQA Health Plan Rating of 54.0, and at least a ~~Three~~Four-Star Rating for Medicare.
2)
~~4)~~ Engage providers through the provision of ~~new~~ Pay for Value (P4V) programs for Medi-Cal, ~~and the new~~ OneCare~~,~~ and Hospital Quality. ~~e programs through incentivize measures related to our STAR rating~~
3)

These top threefour priority goals were chosen to be aligned with CalOptimaCalOptima Health's strategic objectives, the pandemic, as well as continued goals related to access to care and NCQA accreditation. -The 2022 2023 QI Work Pplan details the planned activities to meet the COVID-19 vaccine aim, which include strategies for childhood, COVID-19 and other immunizations, including n, targeted communication and a member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Pplan, 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 OC and OCC. 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 SDOH~~
- ~~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 the 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~~CalOptima Health strategic priorities and the most recent and trended HEDIS, 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~~CalOptima Health's organizational needs and specific needs of ~~CalOptima~~CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on ~~quality of care~~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 2022 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 — 2023~~2~~ QI Work Plan

Quality Improvement Projects~~Methodology~~

QI Project Selection~~s~~ 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)~~ Ppotential quality issue (PQI) review processes
    - ~~, (b)~~ Pprovider and facility reviews~~,~~
    - ~~(c)~~ Ppreventive care audits
    - A~~, (d) a~~ccess to care studies
    - M~~, (e) m~~ember experience surveys
    - ~~, (f)~~ HEDIS results
    - Other opportunities for improvement as identified by subcommittee's data analysis
    - ~~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, LTSS 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 Seniors and Persons with Disabilities (SPD)
- Provisions of chronic, complex ~~case~~care management and ~~case~~care 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 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~~used.

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~~CalOptima Health'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~~CalOptima Health ~~also uses a variety of QI methodologies depending on the type of opportunity for improvement identified.~~ The PDSA 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) including barrier analysis
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
11) As needed, initiate Corrective Action Plan(s), which many include enhanced monitoring and/or re-measurement activities.

Types of QI Projects

CalOptima Health implements several types of improvement projects including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. 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 remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes~~,~~ but is not 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
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

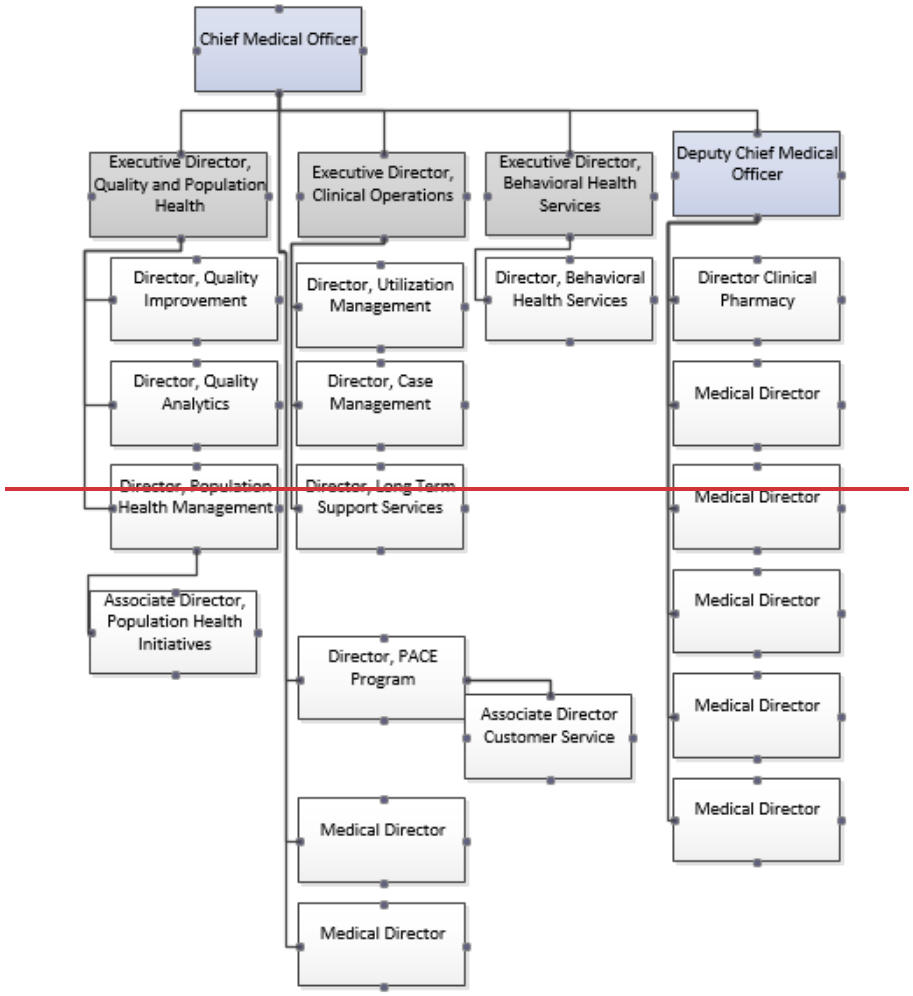
Communication of QI Activities

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 QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to ~~CalOptima~~CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, ~~medical~~ Medical D~~d~~irectors' M~~m~~eetings, Quality Forums and other ongoing ad hoc meetings
- MAC, ~~QCC MAC, WCM FAC and PAC~~PAC and WCM FAC

Quality Program Organization Structure Diagram

As of February 2023



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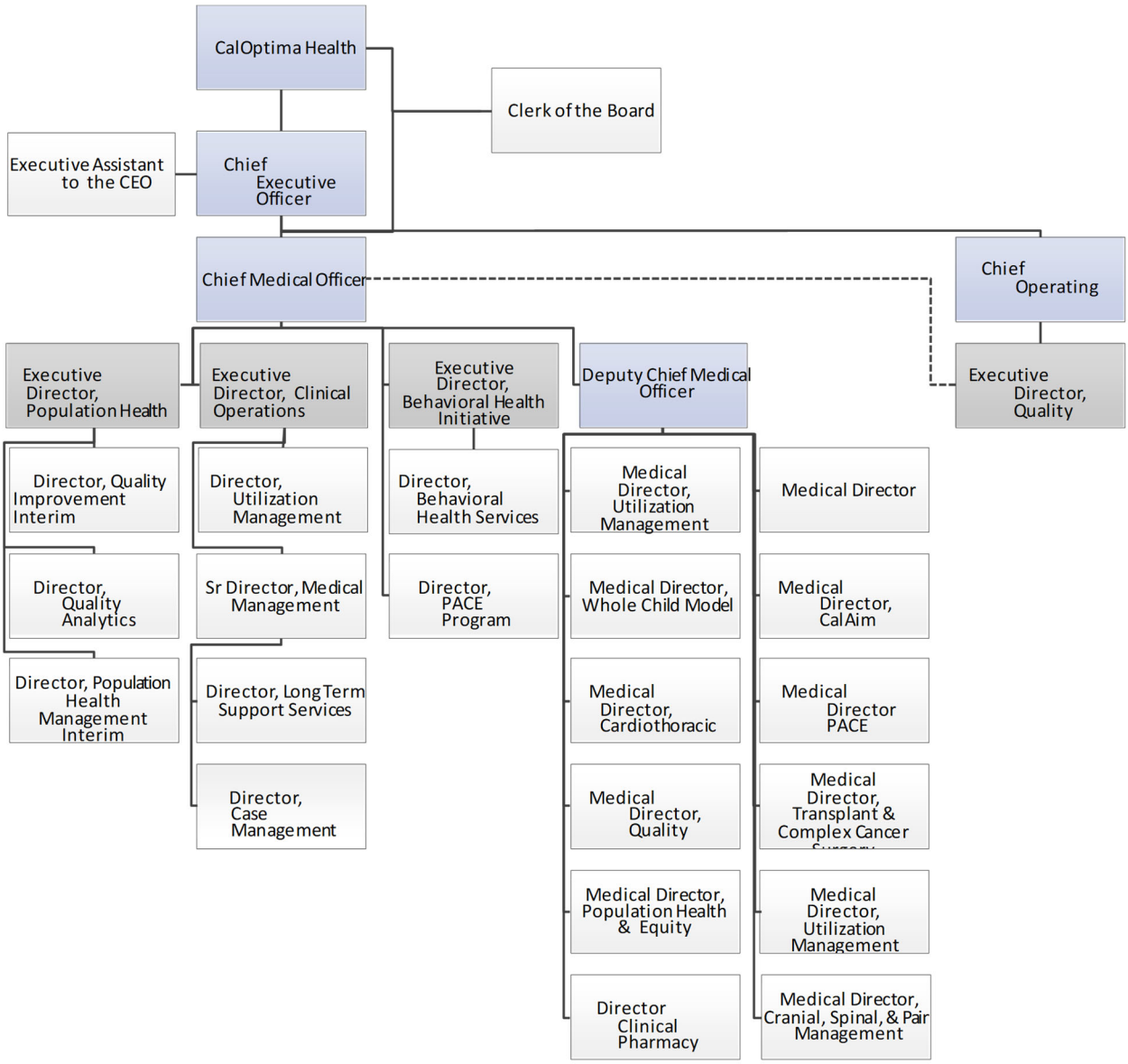

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Quality Improvement Program Resources

~~CalOptima~~CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for ~~CalOptima~~CalOptima Health'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~~CalOptima Health's CMO, ED ~~of~~ ~~Quality~~Q and ED ~~of~~ ~~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 functions, including credentialing, ~~FSRs~~facility site reviews (FSRs), physical accessibility compliance and working with the ED ~~of ,~~ Quality ~~&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.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- ~~Supervisor, Quality Improvement (PQI)~~
- Supervisor, Quality Improvement ~~(Nursing Facilities) (CBAS)~~ (FSR~~, CR~~)
- Supervisor, Quality Improvement (PARS)
- ~~Supervisor, Quality Improvement (Credentialing)~~
- QI Nurse Specialists (RN) (LVN)
- ~~Program Policy Analyst~~
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- ~~(including Intermediate and Senior)~~
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing~~s~~

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~~ ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (~~Pay for Value~~P4V)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- Program Coordinators
- Program Specialists
- Quality Analyst
- Program Assistant

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~~Care Management, UM, Pharmacy Management 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~~ Model of Care 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:

- ~~Associate Director, Population Health Initiatives~~
- ~~Population Health Management Manager (Quality Initiatives)~~
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

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~~CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the ~~Behavioral Health Integration~~BHI 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, 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 UM committees and participates in the QIC and the BMSC.

Director, Clinical Pharmacy Management
Leads the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on ~~casecare~~s~~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 P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, ~~Case~~Care Management
Responsible for ~~Case~~Care Management, Transitions of Care, Complex ~~Case~~Care Management and the clinical operations of Medi-Cal ~~, OCC~~ and ~~OC~~OneCare. 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 (LTSS)
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.

~~Add: Director, Credentialing~~

Staff Orientation, Training and Education

~~CalOptima~~CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

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~~CalOptima Health New Employee Orientation and Boot Camp (~~CalOptima~~CalOptima Health 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, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Reducing BBias and Por romoting IInclusion Training
- and Trauma-Informed Care training

Model of OCare (MOC) relatedAffected employees, contracted providers and practitioner networks are trained at least annually on the Model of Care (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.

CalOptimaCalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptimaCalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptimaCalOptima Health's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in 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 toward 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 summarysummarizing of all quality measures and identification identifyingof significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptimaCalOptima Health 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 oOf Care And and Service

CalOptimaCalOptima Health 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 CalOptimaCalOptima Health 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
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Preventive care, including:
  - Initial Health AssessmentAppointment
  - ~~Initial Health Education~~
  - Behavioral Assessment
- Diagnosis, care and treatment of acute and chronic conditions
- Complex cCarse management including complex care management: ~~For members with multiple and/or complex conditions to obtain access to care and services via the UM and Case Management departments~~
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management
- Member experience
- Patient safety

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~~CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the ~~CalOptima~~CalOptima Health program.

Quality of Clinical Care~~UALITY OF CLINICAL CARE~~

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~~,~~. The department~~and~~ ensures that care and services are rendered appropriately and safely to all ~~CalOptima~~CalOptima Health 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 department-specific and 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~~ Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care ~~casecare~~cases are reviewed by a ~~medical~~ Medical D~~d~~irector who determines a proposed action, dependent on the severity of the ~~case~~~~care~~case. The ~~medical~~ Medical D~~d~~irector presents these ~~casecare~~cases to CPRC, which provides the final action(s). As ~~casecare~~cases are presented to CPRC, the discussion of the ~~case~~care includes appropriate action and leveling of the ~~case~~care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI ~~casecare~~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 recredentialing. Potential quality of care ~~casecare~~case referrals are sent to the QI department from multiple areas at ~~CalOptima~~CalOptima Health, which include~~,~~ but are not limited to~~,~~ P~~p~~rior ~~authorization~~Authorization, ~~concurrent~~ Concurrent ~~review~~Review, ~~case~~~~c~~Care ~~management~~Management, ~~legal~~Legal, ~~compliance~~Compliance, ~~customer~~ Customer ~~service~~Service, ~~pharmacy~~ Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and ~~Grievance and Appeals Department~~GARS to assist the staff on the identification of potential quality issues. -Potential quality of care grievances are reviewed by a ~~m~~Medical D~~d~~irector with clinical feedback provided to the member. -Declined grievances captured by the Customer Service ~~D~~department are similarly reviewed by a ~~m~~Medical D~~d~~irector.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the ~~CalOptima~~CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialed 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~~BH 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~~CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at ~~CalOptima~~CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

~~CalOptima~~CalOptima Health performs credentialing and recredentialing of OP~~p~~s, including~~,~~ 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 Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

~~CalOptima~~CalOptima Health 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 recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

~~CalOptima~~CalOptima Health does not delegate PCP site and medical records review to contracted HMOs, PHCs and SRGs, with the exception of Kaiser Permanente~~. CalOptima does, however, delegate this function to designated health plans~~ in accordance with standards set forth by APL ~~20-006~~22-017. ~~CalOptima~~CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. ~~CalOptima~~CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. ~~CalOptima~~CalOptima Health 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~~CalOptima Health 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 precontracted 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 APL 20-006 and ~~CalOptima~~CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from 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~~CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or ~~corrective action plan (~~CAP~~)~~ follow-up issues. -If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

~~CalOptima~~CalOptima Health 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~~CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. 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 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~~CalOptima Health'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~~,~~ and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either ~~CalOptima~~CalOptima Health'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 &~~ Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to ~~CalOptima~~CalOptima Health'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 using continuous improvement tools (i.e., quality improvement plans or PDSA) 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~~ Medical ~~director~~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 when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and PHM teams 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~~CalOptima Health members.

The QA department activities include design, implementation~~,~~ and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis ~~compared~~ to evaluate goals, establish trends~~,~~ and identify root cause
- Establish measurement benchmarks and goals
- 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, including~~,~~ but not limited to~~,~~ network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include~~,~~ but are not limited to:

- Claims ~~information/activity~~data
- Encounter data
- Utilization data
- Ca~~rs~~e management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS ~~performance~~results
- Member and provider satisfaction surveys

By analyzing data that ~~CalOptima~~CalOptima Health 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 scores and CMS Star Ratings. This information will guide ~~CalOptima~~CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Population Health Management

~~CalOptima~~CalOptima Health strives to provide integrated physical health, behavioral health, LTSS, care coordination and complex ~~ease~~care management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. ~~CalOptima~~CalOptima Health'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 below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

~~CalOptima~~CalOptima Health developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. ~~CalOptima~~CalOptima Health's PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

The PHM Strategy is based on numerous efforts to assess the health and well-being of ~~CalOptima~~CalOptima Health members. Additionally, ~~CalOptima~~CalOptima Health's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care 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~~CalOptima Health 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 2022 are tracked in the QI Work Plan and reported to the QIC.

~~I~~In 2023~~2~~, the PHM Strategy will include greater focus on addressing health inequities and SDOH. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on SDOH and health equity as follows:

- ~~Back-to-school immunization clinics for school-aged children (Tdap, COVID-19 vaccine, etc.)~~
- ~~COVID-19 Member Health Rewards for CalOptima members, with special focus on those experiencing homelessness~~
- ~~Improving COVID-19 vaccine access for homebound members and other high-risk populations~~
- ~~Mobile diaper banks for families of infants and adolescent members in collaboration with Women, Infants & Children (WIC) and the Community Action Partnership~~
- ~~Improving access for eligible CalOptima members to CalFresh benefits~~
- ~~Improving access to breast cancer screenings for Korean and Chinese members via mobile mammography~~
- ~~Remote monitoring for members with chronic conditions~~
- ~~Escape The Vape (Great American Smoke Out) annual event that offers vape and tobacco prevention to school-aged children~~
- ~~Shape Your Life Childhood Obesity Program, with group classes to improve awareness of good nutrition and physical fitness for adolescents~~

~~Member Health Needs Assessment I~~n 2023, the PHM Strategy will continue to focus on addressing health inequities and meeting member's social needs. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

~~I~~

- ~~I~~mproving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- Increasing CalOptima Health's organizational health literacy through the Health Literacy for Equity project, with support from Orange County's Equity in OC Initiative.
- Implementing new Medi-Cal benefits that cover doula and community health worker services.
- Resuming in-person group health education classes in the community to promote healthy eating and active living.
- Implementing a multidisciplinary diabetes program and initiating additional interventions for gestational diabetes and chronic kidney disease.

- Launching the Comprehensive Cancer Screening ~~&~~and Support program to create an ethos of cancer screening across Orange County.

- ~~The PHM team also focuses on improvement projects, such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for 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~~

~~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.~~

~~Sustained Improvement~~

~~Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.~~

~~Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project.~~

~~CalOptimaCalOptima Health may choose to continue the project or pursue another topic.~~

~~Documentation of QI Projects~~

~~Documentation of all aspects of each QI Project is required. Documentation includes, but is not 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~~

~~Remeasurement sampling, data sources, data collection and analysis timelines~~

~~Evaluation of remeasurement performance on each quality measure~~

Health Education and Promotion

The PHM department ~~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. They are designed to achieve behavioral change 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.

PHM supports ~~CalOptima~~CalOptima Health 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 HN providers~~

Managing Members With Emerging Risk

~~CalOptima~~CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and ~~CalOptima~~CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. ~~CalOptima~~CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and ~~Case~~Care Management

~~CalOptima~~CalOptima Health is committed to serving the needs of all members 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 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) ~~or Health Needs Assessment (HNA)~~ for ~~MOC~~ OneCare, SPD, and WCM members~~.~~

- Multiple avenues for referral to ~~case~~care 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 evidence-based guidelines distributed to providers who ~~are relevant to~~address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)~~.~~

- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources~~.~~

- Development of individualized care plans that include input from the member, caregiver, PCP, 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 service quality, timeliness and effectiveness~~.~~

- Ongoing assessment of outcomes~~.~~

~~CalOptima~~CalOptima Health's ~~Case~~Care Management program includes three care management levels that reflect the acuity of needs: complex ~~case~~care management, care coordination and basic ~~case~~care management. Members within defined MOCs — SPD, WCM~~,~~ ~~OCC~~ and OneCare — are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) ~~-~~and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to 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), depending on the results of the member's HRA and/or evaluation or changes in 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 the member) and PCP. For members with more needs, other disciplines are included, such as a ~~medical~~ Medical ~~director~~Director, specialist(s), ~~case~~care manager, ~~behavioral health~~BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- 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~~care 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 Individual Care Plan (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 health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members — occurs at the HN, or at ~~CalOptima~~CalOptima Health for CCN members.
  - Team Composition: member, caregiver or authorized representative, HN ~~medical~~ Medical D~~d~~irector, PCP and/or specialist, ambulatory ~~case~~care manager, hospitalist, hospital ~~case~~care manager and/or discharge planners, HN UM staff, ~~behavioral health~~ BH specialist and social worker

    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Care coordination or complex ~~case~~care management
      - ~~Case~~Care management of high-risk members
      - Coordination of ICPs for high-risk members
      - Facilitating communication among member, PCP, specialists and vendors
      - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment

(HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per ~~ease~~care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole ~~-~~ Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare

~~MOC:~~ Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC) ~~/OC and OCC~~

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 ~~OC~~ OneCare~~and OCC~~. 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 SDOH
- 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.

~~The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptimaCalOptima Health 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 member's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.~~

~~CalOptima~~CalOptima Health's D-SNP care management program includes~~,~~ but is not limited to:

- Complex ~~case~~care management program for a subset of members 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~~care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization~~.~~
- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and ~~at~~ high-risk individuals~~.~~
- Hospital ~~case~~care management program to coordinate care for members during an inpatient admission and discharge planning~~.~~

Care management program focuses on member-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.

~~**Seniors and Persons with Disability (SPD)**~~

~~The goal of case management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.~~

~~**Whole Child Model (WCM)**~~

~~The goal of case management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptimaCalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives case management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.~~

~~**CalAIM's Enhanced Care Management (ECM)**~~

~~Effective January 1, 2022, ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. These members are among the most vulnerable and highest-need Medi-Cal managed care members. ECM reflects a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch and person-centered. The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social and long-term needs for members. Eligible members may participate in ECM and/or Community Supports through CalAIM.~~

~~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. The 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 people 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 Behavioral Health (BH)

~~CalOptima~~CalOptima Health 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~~CalOptima Health 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~~CalOptima Health provides direct oversight, review and authorization of BHT services.

~~CalOptima~~CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

~~CalOptima~~CalOptima Health members can access mental health services directly, without a physician referral, by contacting the ~~CalOptima~~CalOptima Health Behavioral Health Line at 855-877-3885. A ~~CalOptima~~CalOptima Health 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~~BH practitioners within the ~~CalOptima~~CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

~~CalOptima~~CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

~~CalOptima~~CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

~~CalOptima~~CalOptima Health is participating in two of DHCS' incentive programs focused on improving ~~behavioral health~~BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and ~~behavioral health~~BH outcomes, care delivery efficiency and member experience. ~~CalOptima~~CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize ~~behavioral health~~BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county ~~behavioral health~~BH agencies and ~~CalOptima~~CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

~~OC~~ OneCare Behavioral Health ~~and OCC~~

~~In 2022, OC~~ OneCare~~and OCC behavioral health~~BH continues to be fully integrated within ~~CalOptima~~CalOptima Health internal operations. ~~OC~~OneCare ~~and OCC~~ members can access mental health services by calling the ~~CalOptima~~CalOptima Health Behavioral Health Line. Members will be connected to a ~~CalOptima~~CalOptima Health representative for ~~behavioral health~~ assistance.

~~CalOptima~~CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, ~~and~~ subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. 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~~CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2022 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~~~~m~~Medical ~~d~~Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the ~~2022~~ 2023 UM Program Description.

Safety of Clinical CareAFETY OF CLINICAL CARE

Patient Safety Program

Member Patient safety is very important to CalOptimaCalOptima Health; it aligns with CalOptimaCalOptima Health's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate mannerserve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Member Patient safety is integrated into all components of 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.

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 CalOptimaCalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that 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, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety.

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure 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.

- Using FSRs, ~~Physical Accessibility Review Survey (~~PARS~~)~~ and medical record review results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR 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 postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of ~~flu~~ influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment
  - ~~MRSA prevention program – Shared Healthcare Intervention to Eliminate Life-Threatening Dissemination of Multi-drug Resistant Organisms (SHIELD)~~

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Emergency Department Diversion Pilot

In the effort to support hospital partners, members and reduce inappropriate Emergency Department (ED) visits, CalOptima H~~l~~ealth implemented an ED Diversion pilot program. The program has been piloted at one hospital. ~~In 2023, it is planned to~~We plan to expand the program to additional hospital partners in 2023.

The program has ~~the~~ four major goals ~~of~~:

- Promot~~inge~~ communication and member access across all CalOptima Health Networks
- Increase CalAIM Community Supports ~~R~~referrals
- ~~4.~~ Increase PCP follow-up visit within 30 days of an ED visit
-
- Decrease inappropriate ED ~~U~~utilization

~~4. Decrease inappropriate ED Utilization~~

This program provides referrals to CalAIM ~~c~~Community ~~s~~Supports, assists members with appointments to their PCP and specialists, refers members to ~~Case~~Care Management, completes Prior Authorizations, and assists the member with transportation and medication issues.

Member Experience~~ember Experience~~

~~MEMBER EXPERIENCE AND PROVIDER NETWORK~~

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system.

NCQA's Health Insurance Plan Ratings measure customer satisfaction as one of the three dimensions.~~: prevention, treatment and customer satisfaction.~~

~~Annually,~~ CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectation and goals. ~~of the~~ Annually, CalOptima Health~~'~~ fields thes~~s~~ Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and dual-eligible ~~Dual M~~members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population. ~~.~~

Additionally, CalOptima Health reviews ~~the following:~~

~~Monitors its provider network for adequacy as well as access and availability.~~
~~Review~~ customer service metrics~~; and~~, and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" ~~in health care~~ that impact ~~our~~ members at the plan and HN level (including CCN), where appropriate.

Quality of Service~~uality of Service~~

Access to C~~c~~are

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With the rapid growth in CalOptima Health's ~~M~~membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. ~~Marsha….~~
CalOptima Health monitors the following to ensure that members have timely ~~can~~ access to care ~~timely~~:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, ~~S~~specialists and ~~Behavioral Health~~BH ~~P~~practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on ~~S~~state, NCQA~~,~~ and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of ~~P~~practitioners.
- CalOptima Health uses a geo-mapping application to assess the geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, ~~S~~specialists and ~~Behavioral Health P~~BH providers and assesses them against established standards at least annually.
- In order to measure performance, CalOptima Health collects appointment access data from ~~P~~practitioner offices using a timely access survey.
- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- ~~—~~CalOptima Health monitors access to its ~~Member Services~~Customer Service Department on quarterly basis.
-
- In order to ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services

As a health care organization in the diverse community of Orange County, ~~CalOptima~~CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, ~~CalOptima~~CalOptima Health has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. 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; and member information materials translated into ~~CalOptima~~CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all ~~CalOptima~~CalOptima Health programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. ~~CalOptima~~CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- ~~OC~~ OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- ~~three languages: English, Spanish and Vietnamese.~~
- ~~OCC member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic~~
- PACE participant materials are provided in ~~four~~ three languages: English, Spanish~~,~~ and Vietnamese ~~and Korean~~.

~~CalOptima~~CalOptima Health is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. 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 MAC and PAC 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 need as appropriate

Serving a culturally and linguistically diverse membership includes:

- 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-, ethnic-, 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~~CalOptima Health has an annual and continuing monitoring process for delegation oversight to ensure compliance with statutory, regulatory~~,~~ and accreditation requirements. ~~, and compliance to the CalOptima Quality program to ensure continuous improvement of the contracted delegate~~ delegates certain functions and/or processes to delegated HNs that are ~~required to meet all contractual, statutory and regulatory requirements, as well as accreditation standards, ,~~ CalOptima policies and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet ~~CalOptima~~CalOptima Health's QI standards and to participate in ~~CalOptima~~CalOptima Health's QI Program. ~~CalOptima~~CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the ~~Audit &~~Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a s~~a s.~~
~~s~~ystems~~s~~ to audit and monitor ~~HMO, PHC, SRG, VSP, and PMG~~delegated entities' internal operations on a
regular basis.

Delegation Oversight Performance Monitoring includes~~,~~ but is not limited to the following:

- ~~Quality Improvement (~~QI~~)~~ – Kaiser only, ~~Case~~Care Management ~~(CM)~~, Network Management ~~(NET)~~, Credentialing ~~(CR)~~, Utilization Management ~~(UM)~~, Member Experience ~~(ME)~~, Claims, Third Party Liability ~~(TPL)~~, Medicaid Module ~~(MED)~~ and ~~,~~ Second Opinion.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs with the exception of Kaiser Permanente, and remain the responsibility of ~~CalOptima~~CalOptima Health:

- 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~~BH for Medi-Cal and~~,~~ ~~OC~~OneCare ~~and OCC~~

- 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 ~~case~~cases
- ~~Potential Quality Issue~~PQI investigations
- Development of systemwide 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 recredentialing standards for both practitioners and OPs~~
- ~~Credentialing and recredentialing of OPs~~
- Development of UM and ~~Case~~Care 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 2022 Delegation Grid**~~

~~**See Appendix B – 2022 2023 Delegation Grid**~~

~~**In Summary**~~

~~**As stated previously, CalOptimaCalOptima Health 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 members. Together, we can be innovative in developing**~~

~~solutions that meet our diverse members' health care needs. We are truly "Better. Together."~~

Appendix A — ~~2022~~ 2023 QI Work Plan

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2023 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2023 QI Annual Oversight of Program and Work Plan
B. 2022 QI Program Evaluation
C. 2023 UM Program
D. 2022 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. Managed Care Accountability Set (MCAS)
L. Health Network Quality Rating
M. OneCare Performance measures
N. Improvement Projects PIP
O. Improvement Projects PIP (BH)
P. Improvement Projects OneCare CCIP's
Q. PPME/QIPE: HRA's
R. CalAIM
S. Health Equity
T. NCQA Accreditation
U. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. CalOptima Health Comprehensive Community Cancer Screening Program
C. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. 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.
B. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
C. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
D. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
E. Depression Remission or Response for Adolescents and Adults (DRR-E)
F. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
B. Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
C. Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot
D. STARs Measures Improvement

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. MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs
B. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA
C. Blood Lead Screening DHCS APL

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D. Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

2023 Quality Improvement Work Plan

VII. QUALITY OF SERVICE- Access

A. Improve Network Adequacy: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Access Dashboard
E. Improving Access: Subcontracted Network Certification
F. Increase primary care utilization

VIII. QUALITY OF SERVICE- Member Experience

A. STARs Measures Improvement
B. Improve Member Experience/CAHPS

IX. SAFETY OF CLINICAL CARE

A. Emergency Department Diversion Pilot
B. Plan All-Cause Readmissions (PCR)

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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										
2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality 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 April 2023	Marsha Choo	QIC		X			
2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	QIC		X			
2023 Utilization Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	QIC		X			
CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	QIC	SDOH	X			
Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy project	1) 4Q 2022 2) 4Q 2022 3) 3Q 2022	Katie Balderas	QIC	Health Equity	x			
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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Laura Guest	QIC		X			
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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Tyronda Moses	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Marsha Choo	QIC		X			
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.	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	Kelly Giardina	Utilization Management/ QIC		X			
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: 2/21 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	T.T. Nguyen, MD	QIC		X			
Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	QIC					
Improvement Projects OneCare CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study Topic TBD	end of 1Q2023	Helen Syn	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity	X			
Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	QIC					
OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 1Q2023 3. 3Q2023	Linda Lee	QIC					
PPME/QIPE: HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.	1Q23 (5/9 QIC) 2Q23 (8/8 QIC) 3Q23 (11/14 QIC) 4Q23 (February 2024 QIC)	S. Hickman/D. Hood/M. Dankmyer/H. Kim	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	QIC	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quaterly reporting to DHCS	1.4Q2023 2.4Q2023	Diane Ramos/ Natalie Zavala	QIC	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	QIC	Health Equity	X			
CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	QIC					
COVID-19 Vaccination and Communication Strategy	Increase the rate of first time COVID vaccinated members by #%, and increase the rate of fully boosted vaccinated members to #%	1) Communication Strategy of COVID vaccination incentive program through June 30, 2023 end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	QIC		X			
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.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through mutiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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										
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Remission or Response for Adolescents and Adults (DRR-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening, treatment, and follow up 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow-up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening and treatment 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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 HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	QIC		X			
Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	QIC		X			
Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	QIC		X			
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP), Care Management, Centers for Disease Control (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	TBD	QIC					
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	QIC	Health Equity	X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity				
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	QIC	Health Equity	X			
Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	-PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. -Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education -Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, -Launch IVR campaign to members with untested children -Member mailing campaign to members -Lead texting campaign for members -Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	QIC		X			
VII. QUALITY OF SERVICE- Access										
Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) Actively recruit top 3 out-of-network (OON) specialties as shown on QMRT 2) Targeted outreach campaign and incentive to open their panels 3) Business consideration to require providers to participate in all programs. 4) Provider incentive for transportation vendor	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX		X			
Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX		X			
Improve Access: Telephone Access	Live Contacts Rate After 3 Attempts to meet 80%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX		X			
Improve Access: Access Dashboard	Develop an access dashboard for HN performance	1) Identify access measures to include in performance monitoring 2) Develop a methodology to monitor performance	by end of 2Q, 2023	Marsha Choo	MEMX					

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					
Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	QIC					
VIII. QUALITY OF SERVICE- Member Experience										
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	by end of 4Q, 2023	TBD	QIC					
Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Marsha Choo	QIC					
IX. SAFETY OF CLINICAL CARE										
Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Michelle Findlater	QIC					
Plan All-Cause Readmissions (PCR)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by 10% (focus on getting discharge plans w/ PCP appt from hospitals)	<u>Planned Activities:</u> 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	UM Director CM Director LTC Director	QIC		X			

CalOptima Health

2023

Quality Improvement Program

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2023 QUALITY IMPROVEMENT PROGRAM

SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

Richard Pitts, D.O., Ph.D. Date

CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Trieu Tran, M.D., Ph.D. Date

Board of Directors Chair:

_____ _____

Clayton M. Corwin Date

Acting Chair

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Abbreviations

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Event
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems survey
	CAP	Corrective Action Plan
	CBAS	Community-Based Adult Services centers
	CCN	CalOptima Health Community Network
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COPD	Chronic Obstructive Pulmonary Disease
	COO	Chief Operating Officer
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	California Department of Health Care Services
	DMHC	California Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ED PHM	Executive Director, Population Health Management
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs
	ED NO	Executive Director, Network Operations

	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream and Related Entities
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individualized Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long-Term Care
	LTSS	Long-Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Medical Doctor
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facilities
O		
	OC	Orange County
	OCC	OneCare Connect
	OCHCA or HCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIC	Quality Improvement Committee
	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee

	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCP	Primary Care Provider
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician/Hospital Consortia
	PIP	Performance Improvement Project
	PPC	Personal Care Coordinator
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Determinants of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared-Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third-Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2023–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities.

Quality Mission: All people receive equitable, high-quality and value-based care.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy Goals:

1. Embed Quality into the Care Journey: Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.
2. Advance Health Equity: Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.
3. Promote Safety: Prevent harm or death from health care errors.
4. Foster Engagement: Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.
5. Strengthen Resilience: Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.
6. Embrace the Digital Age: Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations and individuals through interoperable, shared and standardized digital data across the care continuum.
7. Incentivize Innovation & Technology: Accelerate innovation in care delivery and incorporate technology enhancements (e.g., telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.
8. Increase Alignment: Develop a coordinated approach to align performance metrics, programs, policy and payment across CMS, federal partners and external stakeholders to improve value. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers and payers.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and stress DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

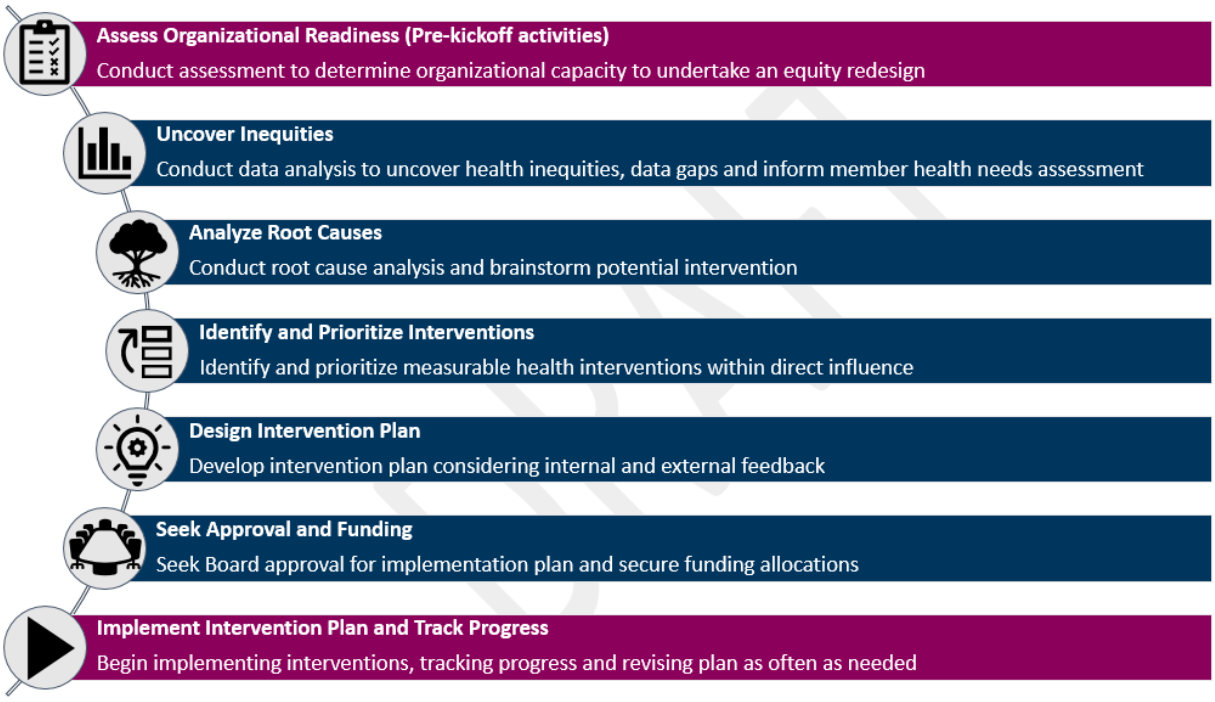
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

Social Determinants of Health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.



Comprehensive Community Cancer Screening and Support Program

CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon and lung cancer in certain smokers. In other words:

- With rare exception, no one should die from breast cancer
- With rare exception, no one should die from cancer of the cervix
- With rare exception, no one should die from cancer of the colon
- With rare exception, no one should die from lung cancer in certain heavy smokers

CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared with many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima Health intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community's daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

1) Increasing community and member awareness and engagement
2) Increasing access to cancer screening

3) Improving member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these cases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15%, compared with a 90% survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix or colon Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent 10-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the [1]second leading cause of cancer-related deaths following lung cancer[1].

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

[1] https://www.science.org/doi/10.1126/science.abd3377

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
    a. CMS Quality
    b. CMS Patient Experience
    c. Leapfrog Hospital and Surgery Center Rating
    d. Leapfrog Hospital Safety Grade
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
    a. Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
    b. Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
    c. Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
    d. Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

CalOptima Health Programs

"Better. Together." is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

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 Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima Health 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 Health through the Whole-Child Model (WCM) Program that went into effect in 2019.

CalOptima Health provides Enhanced Care Management and Community Supports services to address social drivers of health. In 2023, we expand our Community Supports services to the 14 options listed below:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Certain services are not covered by CalOptima Health 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 the Medi-Cal Dental 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 Health has developed specialized care management services. These care 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 Health 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

In July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health 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)

CalOptima Health 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. The 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 Health 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 Health 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 people with disabilities. CalOptima Health 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 Health LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of the frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures including Part C, Part D, and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for enhanced services, such as gym memberships.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to 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 combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests

3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

OneCare Connect

On January 1, 2023, CalOptima Health's OneCare Connect plan ended. Members were transitioned to OneCare.

CalOptima Health Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract through CalOptima Health Direct, CalOptima Health Direct-Administrative and/or CalOptima Health Community Network (CCN) and/or contract with a CalOptima Health Network (HN). CalOptima Health members can choose CCN or one of 12 HNs representing more than 9,400 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

- CalOptima Health Direct-Administrative (COD-A)

  CalOptima Health Direct-Administrative is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

- CalOptima Health Community Network (CCN)

  CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)

- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Health Network	PHC	-
AMVI/Prospect Medical Group	-	SRG
CHOC Health Alliance	PHC	-
Family Choice Medical Group	PHC	SRG
HPN-Regal Medical Group	HMO	-
Kaiser Permanente	HMO	-
Noble Mid-Orange County	SRG	SRG
Optum Care Network - Arta	SRG	SRG
Optum Care Network - Monarch	HMO	SRG
Optum Care Network - Talbert	SRG	SRG
Prospect Medical Group	HMO	-
United Care Medical Group	SRG	SRG
Delegated Vendor	**Medi-Cal**	**OneCare**
Vision Service Plan	VS	VS
MedImpact		PBM

HMO=Health Maintenance Organization
PHC=Physician/Hospital Consortium
SRG=Shared Risk Group
VS=Vision Service
PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims

- Contracting
- Credentialing of practitioners
- Customer service

Membership Demographics

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership

944,975

Program	Members
Medi-Cal	927,086
OneCare Connect	14,385
OneCare (HMO D-SNP)	3,067
Program of All-Inclusive Care for the Elderly (PACE)	437

*Based on unaudited financial reports and includes prior period adjustment. Data from prior to the OneCare Connect program end on January 1, 2023.

Member Demographics (as of December 31, 2022)

Member Age	
0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Quality Improvement Program

CalOptima Health's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and quality of 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 Health 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 subacute care to 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, special health care needs and chronic illnesses.

CalOptima Health's Quality Improvement 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 or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity in practices throughout the organization, including HR best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

Quality Improvement Program Purpose

The purpose of the CalOptima Health QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to members through CalOptima Health CCN and COD-A, as well as our contracted HNs. Through the QI Program — and in collaboration with providers and community partners — CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve our members.

The CalOptima Health QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health'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 Health'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 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 to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.
- Promoting member safety and minimizing risk through the implementation of 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 Health.

- Ensure the annual review and acceptance of the UM Program Description, Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member centric Population Health Management (PHM Program.

In collaboration with the Compliance Audit & Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
- Continuously improve 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.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, high risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure 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.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
  Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values
- Ensure 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 Health 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 Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health 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 Health's state and federal contracts — and to CalOptima Health'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 Health 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 Health'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:

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) has 15 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health 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 bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member (2 seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 15 positions — held by OC SSA — is a standing seat. Each of the remaining 14 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health 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 meetings are 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
- Safety net
- 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 Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

- Family representatives (seven seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members age 18–21 who are current recipients of CCS services; or
    - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (four seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

CalOptima Health Officers' Role in the 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 Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health'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.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

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 Health's Quality teams to ensure QI Program objectives are met..

Medical Director* (Behavioral Health) is the designated behavioral health care physician 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 (ED QI) 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 NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care 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 PHM, makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

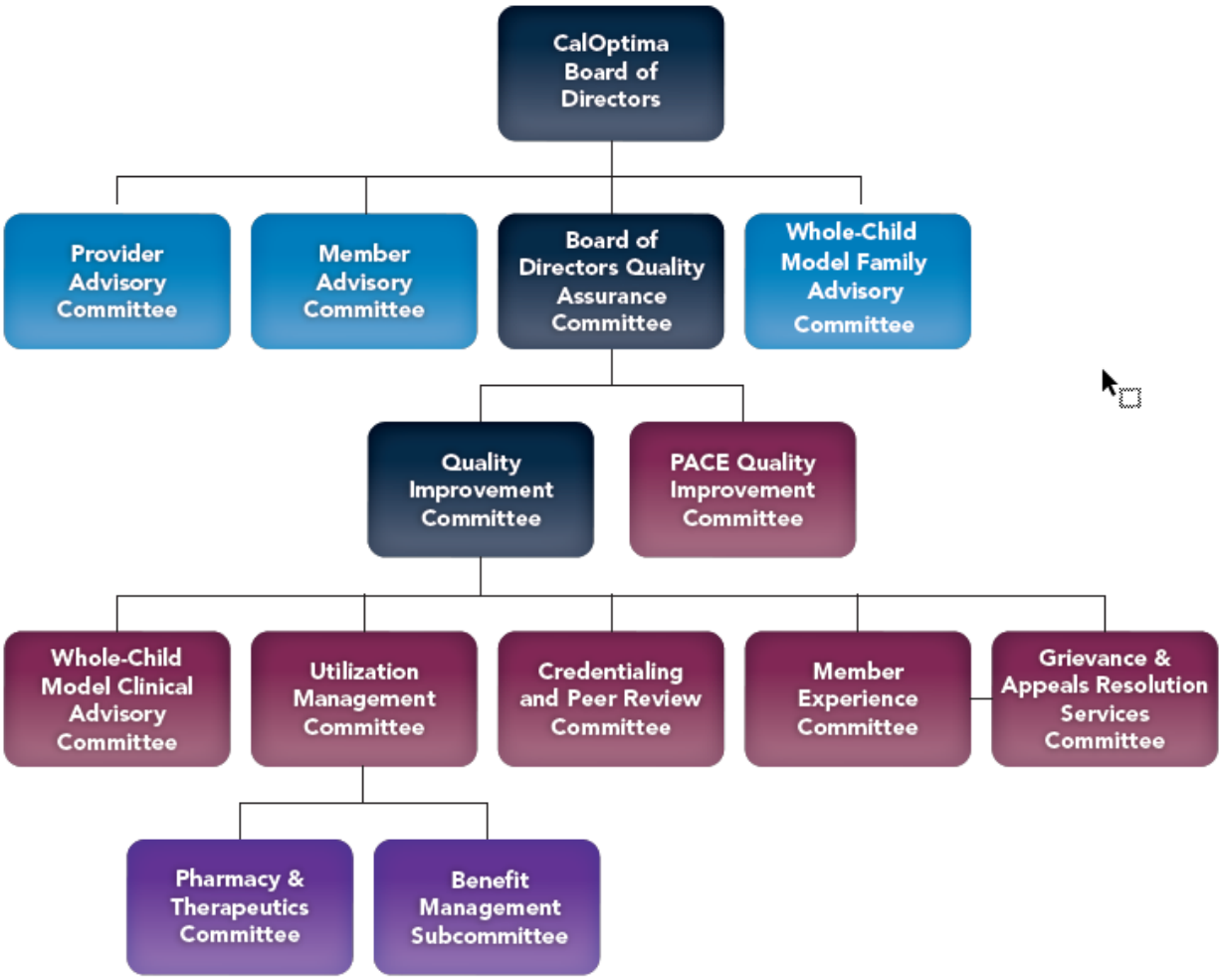
Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs including OneCare and PACE.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates 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 Health's networks and making sure the delivery of accessible, cost-effective and 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.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 (c). Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Committee Organization Structure – Diagram



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 HNs 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 delegated HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral

and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care 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 Health'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 QIC 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 intervention.
- Monitoring overall quality compliance for the organization to quickly resolve deficiencies that affect members

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with Applied Behavior Analysis utilization. Recommendations are made to promote practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIC oversees and coordinates member outcome-related QI 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 Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIC is defined in the QIC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Medical Directors
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director (or Designee)
- CalOptima Health Executive Director, Quality
- CalOptima Health Executive Director, Population Health Management

- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIC is supported by CalOptima Health departments including but not limited to:

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- Population Health Management
- Quality Analytics
- Quality Improvement
- Utilization Management

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, participation by telephone or participation by video conference.

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 QIC 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 QIC charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate QI information to network providers and practitioners
- Tracking of QI 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.

The QIC provides to the QAC quarterly written progress reports of the QIC that describes actions taken, process in meetings QI Program objectives, and improvements made.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health 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 Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health'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, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization 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 is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It

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 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 Health members. The P&T includes practicing physicians (including both CalOptima Health 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 provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T 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 Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health'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 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 Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC 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 Health. 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. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2023, the MEMX committee, which includes the Access

and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2022 and MY 2023 CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health 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 Health 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.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima Health 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 Health 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 Health 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

2023 QI Goals and Objectives

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
2) Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
3) Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

These top three priority goals were chosen to be aligned with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood, COVID-19 and other immunizations, including targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the 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 Health strategic priorities and the most recent and trended HEDIS, 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 Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual 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.

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 — 2023 QI Work Plan

Quality Improvement Projects

QI Project Selection 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:
    - Potential quality issue (PQI) review processes
    - Provider and facility reviews
    - Preventive care audits
    - Access to care studies
    - Member experience surveys
    - HEDIS results
    - 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, LTSS 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 Seniors and Persons with Disabilities (SPD)
- Provisions of chronic, complex care management and care 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 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 used.

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 Health'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.

The PDSA 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) including barrier analysis
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

11) As needed, initiate Corrective Action Plan(s), which many include enhanced monitoring and/or re-measurement activities.

Types of QI Projects

CalOptima Health implements several types of improvement projects including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. 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 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 remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes but is not 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
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

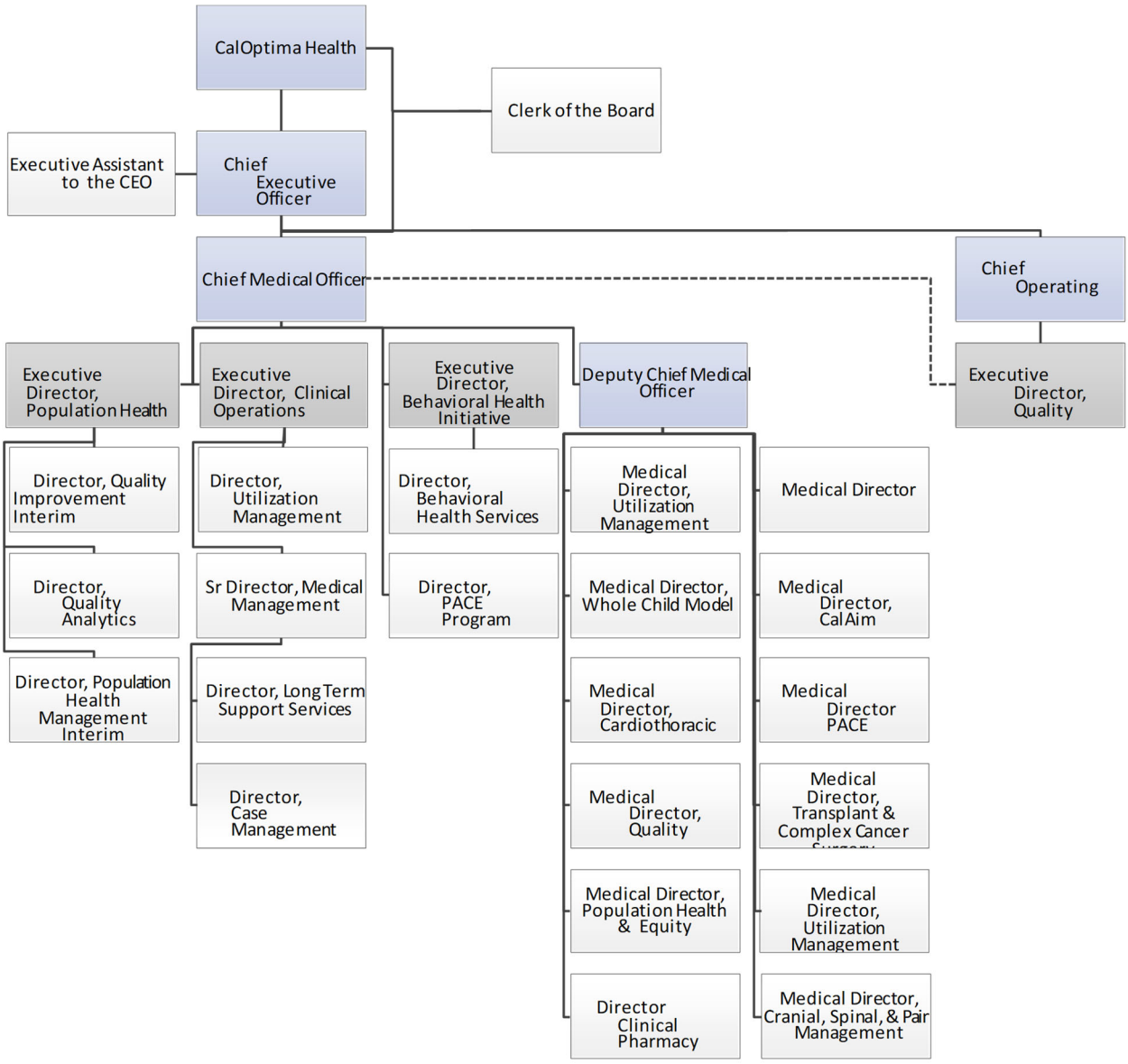
Communication of QI Activities

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 QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, 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
- MAC, PAC and WCM FAC

Quality Program Organization Structure – Diagram

As of February 2023



Quality Improvement Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima Health'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 Health's CMO, ED Q and ED 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 functions, including credentialing, facility site reviews (FSRs), physical accessibility compliance and working with the ED Quality 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.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

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 ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (P4V)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)

- Data Analysts
- Project Managers
- Program Coordinators
- Program Specialists
- Quality Analyst
- Program Assistant

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives. Ensures linkages supporting a whole-person perspective to health care with Care Management, UM, Pharmacy Management 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 Model of Care 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 (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

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 Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI 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, 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 UM committees and participates in the QIC and the BMSC.

Director, Clinical Pharmacy Management

Leads the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management 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 P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. 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 (LTSS)
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.

Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

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 Health New Employee Orientation and Boot Camp (CalOptima Health 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, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Reducing Bias and Promoting Inclusion Training
- Trauma-Informed Care training

Affected employees, contracted providers and practitioner networks are trained at least annually on the Model of Care (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 Health 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 Health. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in 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 toward 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 summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima Health 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 Health 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 Health 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
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management
- Member experience
- Patient safety

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
- Fraud and abuse* as it relates to quality of care

* CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Health program.

Quality of Clinical Care

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. The department ensures that care and services are rendered appropriately and safely to all CalOptima Health 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 department-specific and 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 Directors 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). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. 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 recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care grievances are reviewed by a Medical Director with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialed 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 BH 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 Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including 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 Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health 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 recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima Health does not delegate PCP site and medical records review to contracted HMOs, PHCs and SRGs, with the exception of Kaiser Permanente in accordance with standards set forth by APL 22-017. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health 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 Health 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 precontracted 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 APL 20-006 and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from 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 Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health 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 table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. 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 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 Health'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 and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health'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 Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health'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 using continuous improvement tools (i.e., quality improvement plans or PDSA) 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 when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and PHM teams 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 Health members.

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root cause
- Establish measurement benchmarks and goals
- 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, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys

By analyzing data that CalOptima Health 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 scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Population Health Management

CalOptima Health strives to provide integrated physical health, behavioral health, LTSS, care coordination and complex care management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima Health'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 below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima Health developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima Health's PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima Health members. Additionally, CalOptima Health's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care 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 Health 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 2022 are tracked in the QI Work Plan and reported to the QIC.

In 2023, the PHM Strategy will continue to focus on addressing health inequities and meeting member's social needs. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- Increasing CalOptima Health's organizational health literacy through the Health Literacy for Equity project, with support from Orange County's Equity in OC Initiative.
- Implementing new Medi-Cal benefits that cover doula and community health worker services.
- Resuming in-person group health education classes in the community to promote healthy eating and active living.
- Implementing a multidisciplinary diabetes program and initiating additional interventions for gestational diabetes and chronic kidney disease.
- Launching the Comprehensive Cancer Screening and Support program to create an ethos of cancer screening across Orange County.

Health Education and Promotion

The PHM department 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. They are designed to achieve behavioral change 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.

PHM supports CalOptima Health 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

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members 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 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) for OneCare, SPD, and WCM members
- Multiple avenues for referral to care 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 evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, 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 service quality, timeliness and effectiveness
- Ongoing assessment of outcomes

CalOptima Health's Care Management program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined MOCs — SPD, WCM and OneCare — are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to 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), depending on the results of the member's HRA and/or evaluation or changes in 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 the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- 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 care 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 Individual Care Plan (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 health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members — occurs at the HN, or at CalOptima Health for CCN members.
  - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Care coordination or complex care management
      - Care management of high-risk members
      - Coordination of ICPs for high-risk members
      - Facilitating communication among member, PCP, specialists and vendors
      - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

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 OneCare. 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 SDOH
- 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.

CalOptima Health's D-SNP care management program includes but is not limited to:

- Complex care management program for a subset of members 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 care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization
- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care management program focuses on member-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.

Behavioral Health Integration Services

Medi-Cal Behavioral Health (BH)

CalOptima Health 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 Health 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 Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health 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 BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCareBH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line. Members will be connected to a CalOptima Health representative for assistance.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction

treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. 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 Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2022 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 Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2023 UM Program Description.

Safety of Clinical Care

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. 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 Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring

- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that 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, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure 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
- Using FSRs, PARS and medical record review results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR 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 postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Emergency Department Diversion Pilot

In the effort to support hospital partners, members and reduce inappropriate Emergency Department (ED) visits, CalOptima Health implemented an ED Diversion pilot program. The program has been piloted at one hospital. We plan to expand the program to additional hospital partners in 2023.

The program has four major goals:

- Promote communication and member access across all CalOptima Health Networks
- Increase CalAIM Community Supports referrals
- Increase PCP follow-up visit within 30 days of an ED visit
- Decrease inappropriate ED utilization

This program provides referrals to CalAIM Community Supports, assists members with appointments to their PCP and specialists, refers members to Care Management, completes Prior Authorizations, and assists the member with transportation and medication issues.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system.

NCQA's Health Insurance Plan Ratings measure customer satisfaction as one of the three dimensions.

CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectation and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and dual-eligible members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Quality of Service

Access to Care

With the rapid growth in CalOptima Health's membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. CalOptima Health monitors the following to ensure that members have timely access to care:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on state, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess the geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- In order to measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.
- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service Department on quarterly basis.
- In order to ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. 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; and member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all CalOptima Health programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- PACE participant materials are provided in three languages: English, Spanish and Vietnamese.

CalOptima Health is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. 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 MAC and PAC 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 need as appropriate

Serving a culturally and linguistically diverse membership includes:

- 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-, ethnic-, 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 Health has an annual and continuing monitoring process for delegation oversight to ensure compliance with statutory, regulatory and accreditation requirements.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QI Program. CalOptima Health has a comprehensive interdisciplinary team

that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the following:

- QI – Kaiser only, Care Management, Network Management, Credentialing, Utilization Management, Member Experience, Claims, Third Party Liability, Medicaid Module and Second Opinion.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs with the exception of Kaiser Permanente, and remain the responsibility of CalOptima Health:

- 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)
- BH for Medi-Cal and OneCare
- 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
- PQI investigations
- Development of systemwide 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 UM and Care 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

Appendix A — 2023 QI Work Plan

2023 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2023 QI Annual Oversight of Program and Work Plan
B. 2022 QI Program Evaluation
C. 2023 UM Program
D. 2022 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. Managed Care Accountability Set (MCAS)
L. Health Network Quality Rating
M. OneCare Performance measures
N. Improvement Projects PIP
O. Improvement Projects PIP (BH)
P. Improvement Projects OneCare CCIP's
Q. PPME/QIPE: HRA's
R. CalAIM
S. Health Equity
T. NCQA Accreditation
U. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. CalOptima Health Comprehensive Community Cancer Screening Program
C. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. 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.
B. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
C. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
D. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
E. Depression Remission or Response for Adolescents and Adults (DRR-E)
F. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
B. Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
C. Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot
D. STARs Measures Improvement

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. MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs
B. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA
C. Blood Lead Screening DHCS APL

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D. Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

2023 Quality Improvement Work Plan

VII. QUALITY OF SERVICE- Access

A. Improve Network Adequacy: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Access Dashboard
E. Improving Access: Subcontracted Network Certification
F. Increase primary care utilization

VIII. QUALITY OF SERVICE- Member Experience

A. STARs Measures Improvement
B. Improve Member Experience/CAHPS

IX. SAFETY OF CLINICAL CARE

A. Emergency Department Diversion Pilot
B. Plan All-Cause Readmissions (PCR)

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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										
2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality 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 April 2023	Marsha Choo	QIC		X			
2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	QIC		X			
2023 Utilization Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	QIC		X			
CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	QIC	SDOH	X			
Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy project	1) 4Q 2022 2) 4Q 2022 3) 3Q 2022	Katie Balderas	QIC	Health Equity	x			
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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Laura Guest	QIC		X			
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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Tyronda Moses	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Marsha Choo	QIC		X			
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.	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	Kelly Giardina	Utilization Management/ QIC		X			
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: 2/21 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	T.T. Nguyen, MD	QIC		X			
Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	QIC					
Improvement Projects OneCare CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study Topic TBD	end of 1Q2023	Helen Syn	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity	X			
Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	QIC					
OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 1Q2023 3. 3Q2023	Linda Lee	QIC					
PPME/QIPE: HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.	1Q23 (5/9 QIC) 2Q23 (8/8 QIC) 3Q23 (11/14 QIC) 4Q23 (February 2024 QIC)	S. Hickman/D. Hood/M. Dankmyer/H. Kim	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	QIC	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quaterly reporting to DHCS	1.4Q2023 2.4Q2023	Diane Ramos/ Natalie Zavala	QIC	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	QIC	Health Equity	X			
CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	QIC					
COVID-19 Vaccination and Communication Strategy	Increase the rate of first time COVID vaccinated members by #%, and increase the rate of fully boosted vaccinated members to #%	1) Communication Strategy of COVID vaccination incentive program through June 30, 2023 end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	QIC		X			
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.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through mutiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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										
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Remission or Response for Adolescents and Adults (DRR-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening, treatment, and follow up 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow-up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening and treatment 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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 HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	QIC		X			
Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	QIC		X			
Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	QIC		X			
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP), Care Management, Centers for Disease Control (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	TBD	QIC					
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	QIC	Health Equity	X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity				
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	QIC	Health Equity	X			
Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	-PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. -Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education -Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, -Launch IVR campaign to members with untested children -Member mailing campaign to members -Lead texting campaign for members -Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	QIC		X			
VII. QUALITY OF SERVICE- Access										
Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) Actively recruit top 3 out-of-network (OON) specialties as shown on QMRT 2) Targeted outreach campaign and incentive to open their panels 3) Business consideration to require providers to participate in all programs. 4) Provider incentive for transportation vendor	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX		X			
Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX		X			
Improve Access: Telephone Access	Live Contacts Rate After 3 Attempts to meet 80%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX		X			
Improve Access: Access Dashboard	Develop an access dashboard for HN performance	1) Identify access measures to include in performance monitoring 2) Develop a methodology to monitor performance	by end of 2Q, 2023	Marsha Choo	MEMX					

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					
Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	QIC					
VIII. QUALITY OF SERVICE- Member Experience										
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	by end of 4Q, 2023	TBD	QIC					
Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Marsha Choo	QIC					
IX. SAFETY OF CLINICAL CARE										
Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Michelle Findlater	QIC					
Plan All-Cause Readmissions (PCR)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by 10% (focus on getting discharge plans w/ PCP appt from hospitals)	<u>Planned Activities:</u> 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	UM Director CM Director LTC Director	QIC		X			

2022 Quality Improvement Program Evaluation, 2023 Quality Improvement Program and Work Plan

Quality Assurance Committee Meeting

March 8, 2023

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Quality Improvement (QI) Evaluation

- Annually, CalOptima evaluates the effectiveness of the QI Program:
  - Achievements from the previous year
  - Program structure
  - Responsibility and success of QI initiatives
  - Identification of new initiatives
- Based upon the evaluation of the previous year, the QI Program is revised and updated for the following year.
- The QI Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QI Program.

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2022 QI Program Achievements

- **September 2022:** CalOptima Health received a rating of 4 out of 5 in the NCQA's[1] Medicaid Health Plan Ratings 2022.
  - No other Medi-Cal Plan in California earned a rating higher than 4 out of 5.
  - This is the eighth year in a row that CalOptima Health has received this distinction.
- **October 2022:** Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 OC Visionaries in a special publication of the LA Times OC.
- **November 2022:** CalOptima Health won an award from mPulse Mobile for Most Improved Consumer Experience with its multilingual, two-way SMS texting program that addressed language barriers around food security.
  - The program educated members on the availability and benefits of CalFresh

NCQA[1] - National Committee for Quality Assurance

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2022 QI Program Achievements Cont.

- **November 2022:** CalOptima Health and the Orange County Health Care Agency won the Public-Private Partnership Award from the Orange County Business Council Turning Red Tape Into Red Carpet Awards.
  - The award recognizes both agencies for the launch of Be Well OC's campus in the city of Orange as a first-of-its-kind center that provides comprehensive behavioral health care to improve mental health and substance use disorder services for Orange County residents.

NCQA[1] - National Committee for Quality Assurance

DHCS[2] – Department of Health Care Services

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Review of 2022 Priority Goals

Priority Goals	Accomplishments
1. Develop and implement a comprehensive Health Equity framework	• Created Health Equity and SDOH Workgroup in Jan 2022 • Developed stakeholder survey to collect feedback • Adopted a framework to guide health equity efforts • Established action teams to focus on Health Equity and SDOH Data and Training
2. Improve quality of care and member experience by maintaining NCQA Health Plan Rating of 4.0, and at least a Four-Star Rating for Medicare.	• Received a rating of 4 out of 5 in the National Committee for Quality Assurance's Medicaid Health Plan Ratings in 2022 • Received a Three-Star Overall Rating for Medicare (OneCare) ▪ OneCare's CAHPS performance dropped significantly in each category, resulting in a Part C rating of 2.5
3. Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and Hospital Quality	• Implemented 2022 P4V Programs for Medi-Cal and OneCare Connect • Developed a P4V for OneCare for MY 2023 • Created 2023-2027 Hospital Quality Program

NCQA[1] - National Committee for Quality Assurance

DHCS[2] – Department of Health Care Services

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QI Evaluation Highlights: Program Structure and Oversight

- Added Staffing to Support Quality
  - Executive Director of Quality
  - Quality Medical Director
- Quality Improvement Committee (QIC) met 11 times in 2022
  - 7 Quality Sub-Committees met at least quarterly in 2022
- Updating the QI Committee and Program to include health equity
  - Quality Improvement Health Equity Transformation Program (QIHETP) and Quality Improvement Health Equity Committee (QIHEC)

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QI Evaluation Highlights: Program Initiatives

- Implemented the COVID-19 Vaccination Incentive Program (VIP)
  - 59% of eligible members were vaccinated*
    - OCC and OC have a vaccination rate of 81.8% and 83.9%, respectively; met 80% goal
- Implemented two CalAIM components:
  - Enhanced Care Management (ECM) – 1,045 member participation
  - Community Supports (CS) = 362 member participation
- Implemented the Homeless Health Initiative Program (HHIP)
  - Homeless Response Team (HRT) received and addressed 421 calls
  - Clinical Field Team treated 375 individuals
  - Street Medicine Request for Qualification was launched in July 2022 and providers were selected for pilot to be launched in 2023

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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QI Evaluation Highlights: Performance Outcomes

- Met 13 of 15 MCAS[1] HEDIS measures held to MPL[2]
  - Well-Child Visits in the First 30 Months of Life (First 15 Months) not met
    - CalOptima Health to implement a DHCS[3] required PIP to address this measure; awaiting technical guidance from DHCS[3]
  - Well-Child Visits in the First 30 Month of Life (15 Months - 30 Months) not met
    - CalOptima Health to implement a DHCS[3] PDSA[4]: By 02/28/2023, complete a minimum of 2 outreach attempts to at least 90% of members (approximately 150) with sub-populations with underutilization.

MCAS[1] – Medi-Cal Managed Care Accountability Set; goal is 50th percentile

MPL[2] – Minimum Performance Level

DHCS[3] – Department of Health Care Services

PDSA[4] – Plan Do Study Act

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QI Evaluation Highlights: Member Experience

- Member Experience (CAHPS[1]) Surveys were fielded at both the plan and network level in 2022
  - NCQA Health Plan Rating for Patient Experience at 2 Stars (Medi-Cal)
  - CMS Star Rating
    - Rating of Health Plan at 2 Stars (OneCare)
    - Rating of Health Care Quality 1 Stars (OneCare)
- CalOptima Health submitted all deliverables to DHCS for Annual Network Certification and to CMS[2] for the Triennial Network Adequacy Review
  - We anticipate meeting requirements for mandatory providers types (Medi-Cal Only) and provider to member ratios
  - Area of focus: Timely Access (appointment availability) and Time/Distance Standards

CAHPS[1] – Consumer Assessment of Healthcare Providers and Systems

CMS[2] – Center of Medicare and Medicaid Services

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QI Evaluation Highlights: Patient Safety

- The Post-Acute Infection Prevention Quality Initiative (PIPQI) to reduce antibiotic-resistant bacteria in nursing homes continued in 2022
  - From January to June 2022, the average HAI score decreased from 6.31% to 3.83% (lower HAI score indicate fewer infections in the nursing home)
  - Grant funded ended and program concluded on June 30, 2022.

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Recommendations for 2023

- Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic with programs that support
  - Early detection and cancer screening for breast, cervical, colorectal and lung cancer
  - Targeted interventions and member engagement to well-child visits, blood lead screening and childhood immunizations.
- Incorporate Social Determinants of Health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- Expand quality initiatives to improve member experience, focused on increasing member access to care.

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2023 Quality Improvement Program Description (Work Plan)

Board of Directors Quality Assurance Committee
March 8, 2023

Linda Lee, Executive Director, Quality Improvement

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CalOptima Health

Quality Improvement (QI) Program Process

- The QI Program provides a formal process to systematically monitor and objectively evaluate, track and trend quality, efficiency and effectiveness.
- The QI Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QI Program.

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2023 QI Program Description

- Describes the quality and safety of clinical care, and organizational services provided to our members
- Aligns with the CalOptima Health's five Strategic Priorities and Objectives:
  - Organizational and Leadership Development
  - Overcoming Health Disparities
  - Finance and Resource Allocation
  - Accountabilities and Results Tracking
  - Future Growth
- Aligns with the priorities of our state and federal regulators:
  - Center for Medicare and Medicaid Services (CMS) National Quality Strategy
  - Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

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2023 QI Program Description (cont.)

- Describes the scope of services for each line of business
- Describes the provider network
- Established the 2023 QI Goals and Objectives
  - Goal 1 - Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
  - Goal 2 - Improve quality of care and member experience by obtaining NCQA[1] Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
  - Goal 3 - Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and a Hospital Quality.

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2023 QI Program Description and Revision Highlights

- Updated new program initiatives
  - Health Equity Framework
  - Comprehensive Community Cancer Screening and Support Program
  - Five-Year Hospital Quality Program
- Updated the QI Program Staffing and Resources to reflect current organizational structure
- Updated the QI Committee Structure – removing OneCare Connect committees
- Updated sections in the QI Program to reflect current operational processes and workflows

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2023 QI Work Plan Focus Areas

- Preventive measures and screenings that were impacted during the pandemic with programs that support
  - Early detection and cancer screening for breast, cervical, colorectal and lung cancer
  - Targeted interventions and member engagement to well-child visits, blood lead screening and childhood immunizations.
- Social Determinants of Health (SDoH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- Quality initiatives to improve member experience, focused on increasing member access to care.

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2023 QI Work Plan Revisions: Program Structure and Oversight

Change	Programs
Revised	• Elements of the DHCS Comprehensive Quality Strategy now tracked under CalAIM and Population Health Management Strategy
Added	• OneCare Pay-for-Value Program for MY 2023 • NCQA Health Equity Accreditation by January 2026
Removed	• Quality Withhold for OneCare Connect (ending of OCC program) • BHI Incentive Program (program ended 12/31/22) • Homeless Health Initiatives (now part of CalAIM)

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2023 QI Work Plan Revisions: Quality of Care

Change	Programs
Revised	• Multi-Disciplinary Approach to Improving Diabetes Care now focused on CalOptima Health Community Network Latino Members
Added	• CalOptima Health Comprehensive Community Cancer Screening Program • STARs Measures Improvement • MCAS Performance Measures – Improvement Plans • Focus on Well-Child Visits in the First 30 Months • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) • Depression Remission or Response for Adolescents and Adults (DRR-E) • Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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2023 QI Work Plan Revisions: Quality of Service

Change	Programs
Added	• Access - Increase Primary Utilization • Increase the Initial Health Appointments for new members and annual wellness visits for all members • Member Experience - Stars Measure Improvement • Review and identify STARS measures for focused improvement efforts. • CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan • Improve Member Experience - CAHPS outcomes • Improve Access: Access Dashboard
Removed	• Improve Access: Expanding Network of Providers Accepting New Patients (part of a PIP that ended in 2022)

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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2023 QI Work Plan Revisions: Quality of Service Safety of Clinical Care

Change	Programs
Added	• Emergency Department Diversion Pilot
Removed	• Post-Acute Infection Prevention Quality Incentive (PIPQI) (program ended in June 2022) • Orange County COVID Nursing Home Prevention Program (grant ended May 31, 2022)

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approval of Revision to the Measurement Set for the CalOptima Health Measurement Year 2023 Medi-Cal Quality Pay for Value Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, MPH, Executive Director, Quality Improvement, (714) 867-9655

Recommended Action

1. Approval of Modification of the Measurement Set for the 2023 Health Network Medi-Cal Pay for Value Performance Program for the Measurement Period Effective January 1, 2023, through December 31, 2023.

Background

At the December 1, 2022 meeting, the CalOptima Health Board of Directors reviewed and approved the 2023 Medi-Cal Pay for Value (P4V) program. At that time, the Department of Health Care Services (DHCS) had proposed a draft Medi-Cal Managed Care Accountability Set (MCAS) for measurement year (MY) 2022/reporting year 2023. CalOptima Health staff based the Medi-Cal P4V program on the draft measurement set available at that time. DHCS revised the measurement set on December 31, 2022.

Discussion

Staff proposes revisions to the approved Medi-Cal P4V measurement set to align with the DHCS MCAS measures released on December 31, 2022. The following revisions are recommended:

Measures Approved on December 1, 2022	Recommended Revisions
Follow-up After ED Visit for Substance use – within 7 days	Replace with: Follow-up After ED Visit for Substance use – within 30 days
Comprehensive Diabetes Care – Blood Pressure Control <140/90	remove
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	remove
Prenatal Immunization Status	remove
Follow Up Care for Children Prescribed ADHD Medications - Initiation phase and Continuation/ maintenance phase	remove
Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Antipsychotic medications	remove

See attachment 1 for the full set of measures, including those that do not require revision for alignment with the DHCS MCAS measurement set. Those measures will be used to evaluate CalOptima Health's

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delegated and direct networks.

Fiscal Impact

The fiscal impact for the Medi-Cal P4V Performance Program for the measurement period of January 1, 2023, through December 31, 2023, will be no more than ten percent (10%) of the professional capitation (base rate only) or its equivalent for CalOptima Direct network. Since the funding period will be July 1, 2023, through June 30, 2024, Management will include related expenses in the Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

Alignment with the DHCS MCAS measures promotes consistency with CalOptima Health strategic and quality goals and supports CalOptima Health's efforts to achieve quality outcomes.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachment

1. CalOptima Health's Measurement Year 2023 Quality Incentive Programs

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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Attachment 1

CalOptima Health Measurement Year (MY) 2023
Medi-Cal Pay for Value Program Revised Measurement Set

Revised MY 2023 Medi-Cal Pay for Value (P4V)

CalOptima Health recommends aligning measurement set with the DHCS Medi-Cal Managed Care set released on December 31, 2022 as follows:

Recommended modifications for MY 2023 Medi-Cal P4V

MY 2023 Pay for Value Measures Measurement Set Approved December 1, 2022	Proposed Measurement Set
HEDIS	**HEDIS**
Breast Cancer Screening	Breast Cancer Screening
Cervical Cancer Screening	Cervical Cancer Screening
Child and Adolescent Well-Care Visits: Total	Child and Adolescent Well-Care Visits: Total
Childhood Immunization Status: Combination 10	Childhood Immunization Status: Combination 10
Chlamydia Screening in Women: Total	Chlamydia Screening in Women: Total
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (> 9%)	Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (> 9%)
Controlling High Blood Pressure	Controlling High Blood Pressure
Follow-Up After ED Visit for Mental Illness: 30 Days	Follow-Up After ED Visit for Mental Illness: 30 Days
Immunizations for Adolescents: Combination 2	Immunizations for Adolescents: Combination 2
Lead Screening in Children	Lead Screening in Children
Timeliness of Prenatal Care	Timeliness of Prenatal Care
Postpartum Care	Postpartum Care
Well-Child Visits (WCV) in the First 30 Months of Life: WCV in the First 15 Months (W30)	Well-Child Visits (WCV) in the First 30 Months of Life: WCV in the First 15 Months (W30)
Well-Child Visits (WCV) in the First 30 Months of Life: WCV for Age 15 Months – 30 Months (W30)	Well-Child Visits (WCV) in the First 30 Months of Life: WCV for Age 15 Months – 30 Months (W30)
Follow-up After ED Visit for Substance use – within 7 days	Replace- Follow-up After ED Visit for Substance use – within 30 days
Comprehensive Diabetes Care – Blood Pressure Control <140/90	remove
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	remove
Prenatal Immunization Status	remove
Follow Up Care for Children Prescribed ADHD Medications - Initiation phase and Continuation/ maintenance phase	remove
Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Antipsychotic medications	remove
CAHPS: Member Experience	**CAHPS: Member Experience**
Care Coordination	Care Coordination
Customer Service	Customer Service
Getting Care Quickly	Getting Care Quickly
Getting Needed Care	Getting Needed Care

Attachment 1

CalOptima Health Measurement Year (MY) 2023
Medi-Cal Pay for Value Program Revised Measurement Set

MY 2023 Pay for Value Measures	
Measurement Set Approved December 1, 2022	**Proposed Measurement Set**
Rating of Health Care	Rating of Health Care
Rating of Health Network	Rating of Health Network
Rating of PCP	Rating of PCP
Rating of PCP	Rating of PCP
Rating of Specialist	Rating of Specialist

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approval of New CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie Jeannis, RN, MSN, CCM, Executive Director, Population Health Management, (714) 246-8591
Linda Lee, MPH, Executive Director, Quality, (657) 900-1069

Recommended Action

Approval of new CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

Background/Discussion

CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

In December 2022, the CalOptima Health Board of Directors (Board) approved the Medi-Cal Annual Wellness Visit Initiative. The Medi-Cal Annual Wellness Visit Initiative is a program that gives providers incentives for conducting annual wellness visits, assessing social determinants of health, and reviewing preventive services to improve member quality of care and health outcomes. CalOptima Health also gives incentives to members who complete an annual wellness visit. This program does not include dual eligible members and does not apply to Kaiser Foundation Health Plan Inc.

Policy GG.1132 defines the guidelines for an Annual Wellness Visit for CalOptima Health's Medi-Cal members who are forty-five (45) years or older. The policy outlines program and documentation requirements, criteria for member and provider incentives, and methodology for claims reimbursement.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on December 1, 2022, allocated up to $3.75 million from existing reserves to fund the Medi-Cal Annual Wellness Visit Program through June 30, 2023.

Rationale for Recommendation

CalOptima Health staff recommends that the Board approve new policy GG.1132 to ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations.

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Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachments
1. CalOptima Health Policy GG.1132 – Medi-Cal Annual Wellness Visit Program

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Approve Actions Related to the Medi-Cal Annual Wellness Visit Initiative	April 1, 2023 – June 30, 2023	$3.75 million

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

Policy:	GG.1132p
Title:	**Medi-Cal Annual Wellness Visit**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	04/01/2023
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the program to promote, provide, and document Annual Wellness Visits (AWV) for adult Medi-Cal Members that are forty-five (45) years or older, excluding dual eligible members and members assigned to Kaiser Foundation Health Plan Inc as their Health Network.

II. POLICY

A. The Medi-Cal AWV program aims to ensure that Members complete a comprehensive annual wellness visit with their primary care provider. Members will receive an incentive for completion of an AWV. Qualified Providers will receive an incentive for providing a comprehensive AWV, reporting confirmed condition diagnosis codes, capturing Social Determinants of Health (SDOH) factors and properly documenting such information in Medical Records.

B. The Medi-Cal AWV program includes the following four (4) components:

1. A comprehensive AWV including:

   a. Patient and family health history;

   b. Physical exam;

   c. Assessment for cognitive, behavioral health, functional status, pain, risk factors, SDOH factors, and other health issues as appropriate;

   d. Preventive screening;

   e. Education and counseling services;

   f. Advance care planning; and

   g. Medication review.

2. Validated AWV provider payments:

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a. Qualified Providers shall be reimbursed one hundred twenty-five dollars ($125) per assigned Member, per Service Year for each completed, submitted, and verified AWV billed under:

i. Current Procedural Terminology (CPT) code 99205 with modifier 33 for new patients; or

ii. Current Procedural Terminology (CPT) code 99215 with modifier 33 for established patients.

b. Appropriate CPT codes must be submitted via claims or encounter data to qualify for the one hundred twenty-five dollar ($125) incentive.

3. Provider incentive for completion of the Primary Care Engagement and Clinical Documentation Integrity Program Attestation Form:

a. Qualified Providers may earn a supplemental payment of one hundred dollars ($100) per Member, per Qualified Provider, per Service Year after completing an AWV and an attestation form for each assigned Member. The attestation form is used to document clinical conditions, preventive screens, and diagnosis codes to ensure accuracy and completeness.

4. Member incentive:

a. Once per Service Year, CalOptima Health shall distribute a fifty-dollar ($50) gift card to Members who receive an AWV.

C. For dates of service on or after April 01, 2023, a Qualified Provider is eligible for incentives, if:

1. The assigned Member is eligible for Medi-Cal and forty-five (45) years or older as of December 31 of the Service Year;

2. The Qualified Provider conducts an AWV with the assigned Member within the Service Year;

3. The Qualified Provider addresses and documents all health conditions as noted on the attestation during the AWV and as provided in Section II.B.1.; and

4. The Qualified Provider submits the completed attestation form to CalOptima Health with supporting Medical Records by the required deadline.

III. PROCEDURE

A. CalOptima Health shall conduct provider education and provide technical assistance to improve provider accuracy and completeness of clinical documentation.

B. CalOptima Health shall provide each Qualified Provider an attestation form and Medical Records submission instruction documents for each of their assigned Members via the CalOptima Health Provider Portal.

C. The AWV must be completed in a face-to-face setting, in person and/or via telehealth utilizing a real-time synchronous audio-video platform.

D. The Qualified Provider shall complete all AWVs in the time period required and within the Service Year.

E. The Qualified Provider must appropriately document all of the required elements in the attestation form, with supporting Medical Records, including, but not limited to:

1. Member name;

2. Date of Service;

3. Clinical Assessment;

4. Preventive Health Screening section;

5. Year-Over-Year Chronic and Non-Chronic Conditions sections;

6. Acceptable Qualified Provider signature with credentials; and

7. Date of authentication.

Note: condition diagnosis code(s) (existing and/or new) must be coded according to the *ICD-10 Clinical Modification Guidelines for Coding and Reporting.*

F. The Qualified Provider shall submit the verified attestation form (Attachment A), completed SDOH questionnaire, and supporting Medical Records to the CalOptima Health via CalOptima Health Provider Portal, within the Submission Period, but no later than January 31 following the Service Year.

G. Within thirty (30) calendar days from the end of the Submission Period, the CalOptima Health Coding Initiatives Department shall review the Qualified Provider's attestation form and supporting Medical Records to ensure each condition diagnosis code submitted by the Qualified Provider has appropriate clinical documentation.

1. Upon receipt of Medical Records, CalOptima Health shall retain the Medical Records as set forth in CalOptima Health Policy GG.1603: Medical Records Maintenance.

H. Upon CalOptima Health verification the Qualified Provider has met the conditions as specified in Sections III.E., III.F., and III.G. of this policy, CalOptima Health shall make a supplemental payment in accordance with Section II.B.3.a. of this policy:

1. The CalOptima Health Finance Department shall process a check request and make a supplemental payment of one hundred dollars ($100) per Member, per Service Year, to the Qualified Provider for a completed and verified attestation form, with supporting Medical Records.

2. CalOptima Health shall make supplemental payments to the Qualified Provider on a monthly basis.

3. CalOptima Health shall make supplemental payments within forty-five (45) calendar days from the end of the Submission Month.

I. If CalOptima Health determines that the attestation form or supporting Medical Record(s) is incomplete, lacking clinical justification, or the condition diagnosis codes/SDOH factors are not

reported on a claim or encounter file that reflects the codes documented on the attestation form, CalOptima Health staff will deny payment and provide written notification within thirty (30) calendar days to the Qualified Provider of the determination and rationale for the rejection.

1. Upon receipt of CalOptima Health's notification of incomplete Medical Records, the Qualified Provider may correct or dispute the findings within thirty (30) calendar days and resubmit the completed attestation form, with supporting documentation and/or Medical Records.

J. CalOptima Health will remove and not submit any condition diagnosis codes to the Department of Health Care Services (DHCS) that are not supported in the Medical Records to ensure data reliability and program integrity.

K. CalOptima Health may provide additional provider education and technical assistance and/or make a referral to the Office of Compliance should CalOptima Health determine that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes.

L. If CalOptima Health determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes, and such issues negatively impact quality of care or service delivered to a Member, such matters may be referred as a Potential Quality Issue (PQI) in accordance with CalOptima Health Policy GG.1611: Potential Quality Issues Review Process or referred to the Office of Compliance for further review and investigation depending on the nature and scope of the inaccurate reporting.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. 2023 Primary Care Engagement and Clinical Documentation Integrity Program Attestation Form
B. Accountable Health Communities Health-Related Social Needs Screening Tool
C. CalOptima Health Policy GG.1603: Medical Records Maintenance
D. CalOptima Health Policy GG.1611: Potential Quality Issues Review Process
E. ICD-10-CM Official Guidelines for Coding and Reporting

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2023	GG.1132	Medi-Cal Annual Wellness Visit	Medi-Cal

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IX. GLOSSARY

Term	Definition
Annual Wellness Visit (AWV)	An Annual Wellness Visit (AWV) is a yearly visit to develop or update a personalized prevention plan (PPP) to promote health and help prevent disease based on a Member's health risk factors.
Medical Record	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 Health policy.
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 Health program.
Potential Quality Issue (PQI)	Any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Qualified Provider	For purposes of this policy, contracted Primary Care Provider (PCP), or when applicable, other affiliated PCP, nurse practitioner or physician assistant operating within the provider group.
Social Determinants of Health (SDOH)	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.
Service Year	January 01 through December 31 (12 months).
Submission Month	The month within the submission period in which the attestation form (Attachment A) is submitted to CalOptima Health.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (13 months).

Medi-Cal
CalOptima Health

Primary Care Engagement and Clinical Documentation Integrity Program

Please submit completed form with supporting clinical documentation to fax # 714-571-2491.

Provider Information:	**Check box to confirm the provider completing the assessment. Enter the provider name and NPI if not populated.**
☐ Provider:	**Last, First** **505 City Parkway West Orange CA 92868**
☐ Provider:	

Patient Name:	**Last, First**		
Member ID:	**33333333T**	DOB:	**3/18/1952**
Date(s) of Service:			

Preventative Health Screening(s)

Screening to Consider	**Date Completed**	**Member Refused**	**Not Applicable**
A1c Test	_____	☐	☐
Breast Cancer Screening	_____	☐	☐
Colorectal Cancer Screening	_____	☐	☐
Diabetic Eye Exam	_____	☐	☐

Additional Comments:

_____

Year Over Year Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Type 2 diabetes mellitus with hyperglycemia	E11.65	Diabetes with Chronic Complications	☐	☐	☐
Type 2 diabetes mellitus without complications	E11.9	Diabetes without Complication	☐	☐	☐
Paranoid schizophrenia	F20.0	Schizophrenia	☐	☐	☐
Delusional disorders	F22	Major Depressive, Bipolar, and Paranoid Disorders	☐	☐	☐
Schizoaffective disorder, unspecified	F25.9	Schizophrenia	☐	☐	☐
Unspecified psychosis not due to a substance or known physiological condition	F29	Reactive and Unspecified Psychosis	☐	☐	☐

Year Over Year Non-Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Acute kidney failure with tubular necrosis	N17.0	Acute Renal Failure	☐	☐	☐
Acute kidney failure, unspecified	N17.9	Acute Renal Failure	☐	☐	☐

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_____ _____

Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Authorize and Direct Execution of Amendments to CalOptima Health's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an amendment(s) to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima Health related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima Health contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima Health entered into a new four (4)-year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 62, which extends the Primary Agreement to December 31, 2023. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.

Discussion

Calendar Year (CY) 2023 Mainstream Rates

The mainstream rates for January 1, 2023 through December 31, 2023, were first sent to CalOptima Health as draft rates in September 2022, as updated draft rates in December 2022, and as final rates in January 2023. The rates reflect a rate rebase that now utilizes State Fiscal Year (SFY) 2020 – 2021 experience, including health plan reported rate development templates (RDTs) and encounter data. The rebase also includes the following:

- Base data adjustments for program changes such as:
  - Long-Term Care (LTC) rate increases;
  - Intermediate Care Facility for Developmentally Disabled (ICF/DD) and Freestanding Pediatric Subacute (FS – PSA) LTC per diem rate increases;
  - Hospice rate increase;
  - Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF);
  - Dyadic behavioral health;
  - Doula;
  - Community Health Worker (CHW);
  - Rapid Whole Genome Sequencing; and
  - Community Supports.

- Rate add-ons for the following:

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  - Seniors and Persons with Disabilities (SPD) Community – Based Adult Services (CBAS);
  - Behavioral Health Treatment (BHT) per member per month (PMPM) rates included in the base data development for all rate cells;
  - LTC risk adjustment carve-out with the cost / utilization experience for utilizers of LTC services for 90 days who are not in a LTC aid code will be included in their underlying aid code;
  - Enhanced Care Management (ECM) rate amounts, including the following:
    - Grouping of ECM populations into three distinct populations for rate development;
    - Phase-in of new ECM Populations of Focus (POFs), including the LTC and Children POF;
    - Continuation of the risk corridor for CY 2023 ECM rates;
    - Offset adjustments for the portion of the projected population that is enrolled in multiple care management programs;
    - Assumption changes impacting PMPM costs;
    - Assumption changes impacting ECM enrolled member counts; and
    - Other noteworthy items such as outreach costs and Unsatisfactory Immigration Status (UIS) / Satisfactory Immigration Status (SIS) in ECM.
  - Hospital QAF;
  - Proposition 56 Physician; and
  - Adverse Childhood Experiences (ACEs) Screening, Developmental Screening, Proposition 56 Family Planning.
- Projected non-benefit costs for administrative and underwriting gain loads.
- Project membership assumes that the Public Health Emergency will end in January 2023 and that DHCS will work through the backlog of eligibility redetermination within 14 months.
- Maternity supplemental payments.
- Blending of the SPD & LTC and SPD/Full Dual rate cells for COHS counties.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

Compared to CY 2022 rates, the CY 2023 final rates are 0.2% or $0.63 PMPM higher for Medi-Cal membership in aggregate. Staff projects the net fiscal impact for the period January 1, 2023, through June 30, 2023, will be comparable to assumptions included in the CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget and will include updated rates for the period of July 1, 2023, through December 31, 2023, in the FY 2023-24 Operating Budget.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima Health through the RDT process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima Health operations.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 8

The following is a summary of amendments to the Primary Agreement approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

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A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023

The following is a summary of amendments to the Secondary Agreement approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

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A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021
Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures	December 7, 2017

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(P&Ps) to implement California Senate Bill (SB) 1004.	

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Appointment to the CalOptima Health Board of Directors' Member Advisory Committee

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director Operations, (714) 246-8866

Recommended Actions

The CalOptima Health Member Advisory Committee (MAC) recommends the appointment of Josefina Diaz to serve a three-year term on the MAC as the OneCare Member Representative effective April 6, 2023, for a term ending June 30, 2026.

Background

The CalOptima Health Board of Directors established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of 15 voting members with 14 MAC members serving three-year terms and one standing seat for the representative from the County of Orange Social Services Agency (SSA). The CalOptima Health Board is responsible for the appointment of all MAC members.

Discussion

In November 2022, the MAC was restructured to incorporate three seats from the former OneCare Connect Member Advisory Committee to represent a OneCare voice on the committee. Appointing a family member to the committee will allow for compliance with the current Department of Health Care Services (DHCS) contract requirement for OneCare representation on the MAC.

The MAC requests that the following individual be appointed as a OneCare Member/Family Member:

OneCare Member/Family Member Representative

Josefina Diaz

Josefina Diaz is a former OneCare Connect Member Advisory Committee member who served as a family member representative from 2016 until 2022. A paralegal by trade, Ms. Diaz is a self-employed Public Notary and Legal Document Assistant. Having worked for more than 30 years in the legal community assisting and serving the diverse and special needs population in the Orange County community, Ms. Diaz assists individuals with their legal needs, especially when it comes to translating legal documents in Spanish for those who do not speak English. Ms. Diaz also assists the senior population with questions about elder abuse, advanced healthcare directives, etc. and continues to meet with new clients at senior centers throughout Orange County.

Fiscal Impact

Effective July 1, 2023, each member or family member representative appointed to the MAC may receive a stipend of up to $50 per committee meeting attended. Management will include funding for the stipends in the proposed Fiscal Year 2023-24 and future operating budgets.

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Rationale for Recommendation

CalOptima Health's contract with the DHCS for the D-SNP program known as OneCare requires that CalOptima Health include seats representing the OneCare program on its MAC. By appointment of the recommended candidate, CalOptima Health will continue to meet the terms of its DHCS contract as it relates to its OneCare D-SNP program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Authorize Staff to Modify CalOptima Health's Whole-Child Model Family Advisory Committee Reporting Structure

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Authorize CalOptima Health staff to modify the Whole-Child Model Family Advisory Committee reporting structure; and
2. Approve modifications to CalOptima Health policy AA.1271: Whole Child Model Family Advisory Committee Policy and Procedures to reflect the reporting structure change.

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model, incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County-Organized Health System plans. A provision of the Whole-Child Model program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Health's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Health Board relative to the Whole-Child Model program.

The WCM FAC is comprised of 11 voting members, seven to nine of whom are designated as family representatives and two to four of whom are designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill these seats.

During the COVID-19 public health emergency, Assembly Bill (AB) 361 (Chaptered September 16, 2021), was created, which allowed for temporary relaxation of certain requirements related to teleconferenced meetings. AB 361 was extremely helpful for the WCM FAC as it allowed the family members on this committee to continue attending scheduled meetings remotely and provide important feedback to CalOptima Health. Prior to the COVID-19 emergency, committee members that served on the WCM FAC had resources that enabled them to attend these meetings in-person.

Discussion

Staff requests the Board's approval to restructure the WCM FAC to report to the Quality Assurance Committee. With Governor Newsom ending the COVID-19 State of Emergency on February 28, 2023, AB 361 is no longer in effect, and committee members now need to operate under AB 2449, which includes limited options for participating remotely. Because of the nature of the WCM FAC being comprised of family members that have and care for children with special needs, they often experience difficulty in finding caregivers in order to attend quarterly meetings in-person. Committee members have voiced that a virtual option would enable their participation as well as serve as a helpful

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recruitment tool. Changing the reporting structure of this committee will continue to allow the important and valuable feedback to CalOptima Health from committee members on the Whole-Child Model program.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Allowing modifications to the WCM FAC will provide flexibility to WCM FAC members to promote participation and enable CalOptima Health to receive valuable guidance and advice in serving WCM members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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Policy:	AA.1271
Title:	**Whole-Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/07/2018
Revised Date:	04/06/2023
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima Health's Board of Directors (Board), the WCM FAC shall report to the CalOptima Health ~~Board~~Quality Assurance Committee (QAC) and shall provide advice and recommendations to the CalOptima Health Board and CalOptima Health staff in regard to California Children's Services (CCS) provided by CalOptima Health Medi-Cal's implementation of the WCM.

B. CalOptima Health's Board encourages Member and community involvement in CalOptima Health programs.

C. WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima Health shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Health Members.

F. An organization may have no more than one (1) employee or representative on the WCM MAC at any one time.

G. An individual may participate in no more than one (1) CalOptima Health Advisory Committee at any one time.

Back to Item

Back to Agenda

H. In accordance with CalOptima Health Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a three (3)-year term with no limits on the number of terms a representative may serve.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Health Member who is a current recipient of CCS services;

   b. CalOptima Health Members eighteen (18) ~~-~~to twenty-one (21) years of age who are current recipients of CCS services; or

   c. Current CalOptima Health Members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

   a. Community-based organizations; or

   b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC ~~member~~Member or family member representative.

5. A family representative, in accordance with Section II.H.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima Health shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Health Policy GA.5004: Travel and Business Meal Policy.

I. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to fifty dollars ($50) per meeting to a Member or family representative serving on the WCM FAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

J. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

K. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

   a. If there is no viable candidate among the applicants, CalOptima Health shall conduct recruitment, per Section III.B.2 of this Policy.

3. A new WCM FAC member appointed to fill a mid-term vacancy~~,~~ shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

L. On a bi-annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this policy.

1. The WCM FAC chair and vice chair may serve one (1) two (2) year term.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima Health's Board.

M. The WCM FAC chair or vice chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

   a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

   b. Forward the prospective slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended slate of candidate(s) shall be forwarded to CalOptima ~~Health's~~Health Board of Directors' QAC for review and approval of a recommendation to the Board.

N. CalOptima ~~Health's~~Health Board of Directors' QAC shall ~~approve all~~recommend appointments, reappointments, and chair and vice chair appointments to the WCM FAC to the Board.

O. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

P. WCM FAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima Health staff prior to the meeting. CalOptima Health staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima

Health staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima Health's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima Health website; and/or

   c. Outreach to community stakeholders

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the WCM FAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting:

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for the slate of candidates to WCM FAC for review and approval. Candidates interested in the Chair and Vice Chair positions shall submit a letter of interest to the Staff to the Advisory Committees indicating their interest in the chair and the vice chair seats.

2. Chair and vice chair candidates will be reviewed at the first WCM FAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to the Board for appointment. Following WCM FAC's approval the proposed chair, vice chair shall be submitted to CalOptima Health's Board of Directors' QAC for a recommendation and then sent to the Board of Directors for approval.

3. The WCM FAC members' terms shall be effective upon final approval by the CalOptima Health Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the next WCM FAC meeting.

4. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee - Application
B. Whole Child Model Member Advisory Committee - Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee - Application
D. Whole Child Model Community Advisory Committee - Applicant Evaluation Tool

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Board Resolution 17-1102-01
C. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Health Policy GA.5004: Travel and Business Meal Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/07/2018	Department of Health Care Services (DHCS)	Approved as Submitted
07/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	08/06/2020	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	12/01/2022	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	04/06/2023	AA.1271	Whole-Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Health Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Policy:	AA.1271
Title:	**Whole-Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/07/2018
Revised Date:	04/06/2023
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This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

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   b. CalOptima Health Members eighteen (18) to twenty-one (21) years of age who are current recipients of CCS services; or

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M. The WCM FAC chair or vice chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

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    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

    b. Forward the prospective slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended slate of candidate(s) shall be forwarded to CalOptima Health Board of Directors' QAC for review and approval of a recommendation to the Board.

N. CalOptima Health Board of Directors' QAC shall recommend appointments, reappointments, and chair and vice chair appointments to the WCM FAC to the Board.

O. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

P. WCM FAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima Health staff prior to the meeting. CalOptima Health staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima

Health staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima Health's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima Health website; and/or

   c. Outreach to community stakeholders

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the WCM FAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting:

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

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1. The nomination ad hoc subcommittee shall forward its recommendation for the slate of candidates to WCM FAC for review and approval. Candidates interested in the Chair and Vice Chair positions shall submit a letter of interest to the Staff to the Advisory Committees indicating their interest in the chair and the vice chair seats.

2. Chair and vice chair candidates will be reviewed at the first WCM FAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to the Board for appointment. Following WCM FAC's approval the proposed chair, vice chair shall be submitted to CalOptima Health's Board of Directors' QAC for a recommendation and then sent to the Board of Directors for approval.

3. The WCM FAC members' terms shall be effective upon final approval by the CalOptima Health Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the next WCM FAC meeting.

4. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee - Application
B. Whole Child Model Member Advisory Committee - Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee - Application
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D. CalOptima Health Policy GA.5004: Travel and Business Meal Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/07/2018	Department of Health Care Services (DHCS)	Approved as Submitted
07/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
05/02/2019	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
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Revised	08/06/2020	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
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IX. GLOSSARY

Term	Definition
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Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Health Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
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Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee
Member Application
2023

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a resume or biography listing your qualifications and include signed authorization forms. For questions, please call 714-347-5785.

Name: _____ Primary Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

- ☐ Authorized representatives, which includes parents, foster parents and caregivers, of a CalOptima Health member who is currently receiving CCS services;
- ☐ CalOptima Health members ages 18–21 who are currently receiving of CCS services;
- ☐ Current CalOptima Health members over the age of 21 who had received CCS services before aging out

Four seats are available with a term beginning July 1, 2023, through June 30, 2025. One seat is available to fulfill an existing term through June 30, 2024.

* Interested candidates for the Whole-Child Model Family Advisory Committee (WCM FAC) member or family member seats must reside in Orange County and be enrolled in CalOptima Health Medi-Cal and/or CCS/WCM or must be a family member of an enrolled CalOptima Health Medi-Cal and CCS/WCM member. The member seat is eligible for a $50 per meeting stipend.

CalOptima Health Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

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Please tell us whether you have been a CalOptima Health member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with CCS:_____

_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

If selected, are you able to commit to attending WCM FAC meetings every other month, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

If selected as a representative on WCM FAC, do you agree that you will complete the required compliance courses within the appointed time frame? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

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Please supply two references (professional, community or personal):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima Health to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

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LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole-Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima Health.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**
Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima Health staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Health Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima Health
Office of the Clerk of the Board
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

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RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole-Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under HIPAA and will not be disclosed by CalOptima Health without separate authorization, unless disclosure is permitted by HIPAA without authorization or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Submit this application, along with a biography or resume to:

CalOptima Health
Attn: Cheryl Simmons
Office of the Clerk of the Board
505 City Parkway West
Orange, CA 92868

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org

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CalOptima Health

Applicant Name:

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat:
Authorized Family Member

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee
Community Application
2023

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State ZIP: _____ Fax Number: _____

Date: _____ Email: _____

I hereby submit my application for the following Whole-Child Model Family Advisory Committee (WCM FAC) Community Representative seats, and I understand that service on the WCM FAC is on a voluntary basis with no stipend:

☐ **Community-based organizations**

☐ **Consumer advocate**

All appointments are for a two-year period beginning July 1, 2023 through June 30, 2025. These seats are subject to continued eligibility to hold a Community Representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima Health population receiving California Children's Services (CCS) services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

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2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima Health?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

7. If selected, are you able to commit to attending bi-monthly WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

9. If selected as a representative on WCM FAC, do you agree that you will complete the required compliance courses within the appointed time frame? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

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Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

_____

Print Name

Submit this application, along with a biography or resume to:

CalOptima Health
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons
Office of the Clerk of the Board

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org

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CalOptima Health

Applicant Name:

WCM Family Advisory Committee
Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: Community Based Organization or Consumer Advocate

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima Health programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35

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Financial Summary

February 28, 2023

Board of Directors Meeting
April 6, 2023

Nancy Huang, Chief Financial Officer

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Financial Highlights: February 2023

February					July - February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
976,552	913,151	63,401	6.9%	Member Months	7,562,378	7,305,918	256,460	3.5%
320,752,951	329,850,106	(9,097,155)	(2.8%)	Revenues	2,621,579,775	2,673,516,085	(51,936,310)	(1.9%)
287,055,217	297,363,354	10,308,137	3.5%	Medical Expenses	2,424,662,289	2,500,925,224	76,262,935	3.0%
15,108,328	18,757,199	3,648,871	19.5%	Administrative Expenses	119,454,202	142,318,218	22,864,016	16.1%
18,589,406	**13,729,553**	**4,859,853**	**35.4%**	**Operating Margin**	**77,463,284**	**30,272,643**	**47,190,641**	**155.9%**
				Non-Operating Income (Loss)				
3,596,217	500,000	3,096,217	619.2%	Net Investment Income/Expense	44,644,767	4,000,000	40,644,767	1016.1%
145,136	90,835	54,301	59.8%	Net Rental Income/Expense	946,390	726,680	219,710	30.2%
(319)	-	(319)	(100.0%)	Net MCO Tax	22,542	-	22,542	100.0%
(1,478,218)	(2,077,922)	599,704	28.9%	Grant Expense	(22,523,672)	(11,688,310)	(10,835,362)	(92.7%)
15	-	15	100.0%	Other Income/Expense	60	-	60	100.0%
2,262,831	**(1,487,087)**	**3,749,918**	**252.2%**	**Total Non-Operating Income (Loss)**	**23,090,086**	**(6,961,630)**	**30,051,716**	**431.7%**
20,852,237	**12,242,466**	**8,609,771**	**70.3%**	**Change in Net Assets**	**100,553,371**	**23,311,013**	**77,242,358**	**331.4%**
89.5%	90.2%	(0.7%)		Medical Loss Ratio	92.5%	93.5%	(1.1%)	
4.7%	5.7%	1.0%		Administrative Loss Ratio	4.6%	5.3%	0.8%	
5.8%	4.2%	1.6%		Operating Margin Ratio	3.0%	1.1%	1.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.5%	90.2%	(0.7%)		*MLR (excluding Directed Payments)	92.2%	93.5%	(1.4%)	
4.7%	5.7%	1.0%		*ALR (excluding Directed Payments)	4.8%	5.3%	0.5%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: February 2023 (in millions)

February				July-February		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
19.7	13.3	6.4	Medi-Cal	81.0	38.2	42.8
(0.2)	(0.0)	(0.1)	OCC	(1.2)	(3.0)	1.8
(1.4)	0.2	(1.6)	OneCare	(2.8)	(4.6)	1.7
0.5	0.4	0.2	PACE	1.1	(0.0)	1.1
(0.0)	(0.0)	(0.0)	MSSP	(0.5)	(0.3)	(0.2)
18.6	**13.7**	**4.9**	**Total Operating Income (Loss)**	**77.5**	**30.3**	**47.2**
			Non-Operating Income (Loss)			
3.6	0.5	3.1	Net Investment Income/Expense	44.6	4.0	40.6
0.1	0.1	0.1	Net Rental Income/Expense	0.9	0.7	0.2
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(1.5)	(2.1)	0.6	Grant Expense	(22.5)	(11.7)	(10.8)
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
2.3	**(1.5)**	**3.7**	**Total Non-Operating Income/(Loss)**	**23.1**	**(7.0)**	**30.1**
20.9	**12.2**	**8.6**	**TOTAL**	**100.6**	**23.3**	**77.2**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) February 2023: $20.9 million, favorable to budget $8.6 million or 70.3%
  - Year To Date (YTD) July – February 2023: $100.6 million, favorable to budget $77.2 million or 331.4%
- Enrollment
  - MTD: 976,552 members, favorable to budget 63,401 or 6.9%
  - YTD: 7,562,378 members, favorable to budget 256,460 or 3.5%
  - Favorable enrollment primarily driven by a pause in Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency (PHE)
  - Effective January 1, 2023, OneCare Connect members transitioned to One Care

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $320.8 million, unfavorable to budget $9.1 million or 2.8% driven by Medi-Cal Line of Business (MC LOB):
    - $51.0 million due to COVID-19 and Proposition 56 risk corridor reserves
    - Offset by $42.9 million of favorable volume related variance, premium capitation rates, and California Housing and Homelessness Incentive Program (HHIP)
  - YTD: $2,621.6 million, unfavorable to budget $51.9 million or 1.9% driven by MC LOB:
    - $323.2 million due to COVID-19, Proposition 56 and Enhanced Care Management (ECM) risk corridor reserves
    - Offset by $135.2 million of Fiscal Year (FY) 2021 hospital Directed Payments (DP) and $125.3 million primarily from favorable volume related variance and premium capitation rates

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $287.1 million, favorable to budget $10.3 million or 3.5% driven by MC LOB:
    - Managed Long-Term Services and Supports (MLTSS) favorable variance of $13.5 million due to low utilization and Incurred But Not Reported (IBNR) claims
    - Facilities Claims favorable variance of $2.3 million
    - Net unfavorable variance of $2.0 million from all other medical expense categories

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FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $2,424.7 million, favorable to budget $76.3 million or 3.0% driven by MC LOB:
    - Provider Capitation favorable variance of $118.3 million primarily due to updated logic for Proposition 56
    - Favorable variances totaling $73.6 million from Facilities, Professional and MLTSS claims due to lower than budgeted utilization and IBNR
    - Offset by $105.9 million in Other Medical Expenses due primarily to FY 2021 hospital DP

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FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $15.1 million, favorable to budget $3.6 million or 19.5%
    - Other Non-Salary expenses favorable variance of $2.4 million
    - Salaries & Benefits expense favorable variance of $1.3 million
  - YTD: $119.5 million, favorable to budget $22.9 million or 16.1%
    - Other Non-Salary expenses favorable variance of $14.2 million
    - Salaries & Benefits expense favorable variance of $8.7 million

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $2.3 million, favorable to budget $3.7 million or 252.2%
    - Non-operating gain is primarily due to Net Investment Income of $3.6 million, offset by Grant Expense of $1.5 million
  - YTD: $23.1 million, favorable to budget $30.1 million or 431.7%
    - Non-operating gain is primarily due to Net Investment Income of $44.6 million, offset by Grant Expense of $22.5 million

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 89.5% (89.5% excluding DP), Budget 90.2%
  - YTD: Actual 92.5% (92.2% excluding DP), Budget 93.5%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.7% (4.7% excluding DP), Budget 5.7%
  - YTD: Actual 4.6% (4.8% excluding DP), Budget 5.3%
- Balance Sheet Ratios
  - *Current ratio: 1.5
  - Board-designated reserve level: 1.83
  - Net-position: $1.5 billion, including required Tangible Net Equity (TNE) of $102.4 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: February 2023

February					July - February			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
138,256	138,273	(17)	(0.0%)	SPD	1,030,545	1,012,331	18,214	1.8%
305,476	303,842	1,634	0.5%	TANF Child	2,431,598	2,445,234	(13,636)	(0.6%)
142,354	130,035	12,319	9.5%	TANF Adult	1,086,747	1,069,692	17,055	1.6%
3,112	3,483	(371)	(10.7%)	LTC	25,910	26,968	(1,058)	(3.9%)
357,707	308,205	49,502	16.1%	MCE	2,751,062	2,515,943	235,119	9.3%
11,873	11,839	34	0.3%	WCM	94,641	94,220	421	0.4%
958,778	**895,677**	**63,101**	**7.0%**	**Medi-Cal Total**	**7,420,503**	**7,164,388**	**256,115**	**3.6%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,342	**16,989**	**353**	**2.1%**	**OneCare**	**52,224**	**49,912**	**2,312**	**4.6%**
432	**485**	**(53)**	**(10.9%)**	**PACE**	**3,466**	**3,731**	**(265)**	**(7.1%)**
472	**568**	**(96)**	**(16.9%)**	**MSSP**	**3,778**	**4,544**	**(766)**	**(16.9%)**
976,552	**913,151**	**63,401**	**6.9%**	**CalOptima Total**	**7,562,378**	**7,305,918**	**256,460**	**3.5%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: February 2023 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	589,198	357,707	11,873	958,778		17,342	432	472	976,552
REVENUES									
Capitation Revenue	146,130,427	$ 118,568,968	$ 21,651,571	$ 286,350,966	$ (96,982)	$ 30,615,833	$ 3,673,075	$ 210,059	$ 320,752,951
Total Operating Revenue	146,130,427	118,568,968	21,651,571	286,350,966	(96,982)	30,615,833	3,673,075	210,059	320,752,951
MEDICAL EXPENSES									
Provider Capitation	44,983,511	51,773,662	7,196,355	103,953,528	126,555	13,034,914			117,114,997
Facilities	31,766,893	25,201,017	3,846,744	60,814,654	(341,046)	5,389,131	457,180		66,319,919
Professional Claims	25,807,208	14,614,556	1,447,802	41,869,566	82,948	1,251,932	1,102,304		44,306,750
Prescription Drugs	(273,976)			(273,976)	(44,994)	9,044,144	420,831		9,146,005
MLTSS	29,187,044	3,817,874	2,102,410	35,107,328	(139,301)	80,071	98,686	24,472	35,171,256
Incentive Payments	2,487,784	3,834,561	48,516	6,370,861	49,474	366,596	(52,988)		6,733,944
Medical Management	2,883,639	2,023,061	358,087	5,264,786	248,056	907,642	964,331	149,198	7,534,013
Other Medical Expenses	433,540	283,077	11,716	728,333					728,333
Total Medical Expenses	137,275,642	101,547,808	15,011,630	253,835,081	(18,308)	30,074,430	2,990,345	173,670	287,055,217
Medical Loss Ratio	93.9%	85.6%	69.3%	88.6%	18.9%	98.2%	81.4%	82.7%	89.5%
GROSS MARGIN	**8,854,784**	**17,021,160**	**6,639,941**	**32,515,885**	**(78,673)**	**541,403**	**682,730**	**36,389**	**33,697,734**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				8,738,816	27,493	735,978	132,220	72,289	9,706,794
Professional Fees				792,868	(12,863)	20,833		1,333	802,172
Purchased Services				1,062,728	74,310	159,197	14,874		1,311,109
Printing & Postage				368,859	(2,183)	110,750	1,752		479,177
Depreciation & Amortization				367,101			1,311		368,412
Other Expenses				2,027,234	1,120	4,310	7,199	6,690	2,046,552
Indirect Cost Allocation, Occupancy				(551,240)		925,930	13,950	5,471	394,112
Total Administrative Expenses				**12,806,365**	**87,878**	**1,956,997**	**171,306**	**85,783**	**15,108,328**
Admin Loss Ratio				4.5%	-90.6%	6.4%	4.7%	40.8%	4.7%
INCOME (LOSS) FROM OPERATIONS				19,709,520	(166,551)	(1,415,594)	511,424	(49,393)	18,589,406
INVESTMENT INCOME									3,596,217
NET RENTAL INCOME									145,136
TOTAL MCO TAX				(319)					(319)
TOTAL GRANT EXPENSE				(1,478,218)					(1,478,218)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ 18,230,998**	**$ (166,551)**	**$ (1,415,594)**	**$ 511,424**	**$ (49,393)**	**$ 20,852,237**
BUDGETED CHANGE IN NET ASSETS				11,186,459	(41,413)	192,248	353,994	(39,657)	12,242,466
VARIANCE TO BUDGET - FAV (UNFAV)				$ 7,044,539	$ (125,138)	$ (1,607,842)	$ 157,430	$ (9,736)	$ 8,609,771

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CalOptima Health

Consolidated Revenue & Expenses: February 2023 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	4,574,800	2,751,062	94,641	7,420,503	86,185	52,224	3,466	3,778	7,562,378
REVENUES									
Capitation Revenue	1,187,919,592	$ 966,518,348	$ 178,192,814	$ 2,332,630,754	$ 175,307,577	$ 83,173,887	$ 28,875,289	$ 1,592,269	$ 2,621,579,775
Total Operating Revenue	1,187,919,592	966,518,348	178,192,814	2,332,630,754	175,307,577	83,173,887	28,875,289	1,592,269	2,621,579,775
MEDICAL EXPENSES									
Provider Capitation	296,020,532	363,427,825	69,281,116	728,729,474	72,131,559	31,590,961			832,451,993
Facilities	258,312,973	226,095,175	42,874,156	527,282,303	27,166,699	15,469,246	6,500,603		576,418,852
Professional Claims	181,584,986	112,721,821	11,520,664	305,827,471	8,749,963	3,517,946	7,487,395		325,582,776
Prescription Drugs	(2,298,011)	(2,287,072)	5,604	(4,579,479)	40,034,793	25,848,502	3,216,848		64,520,664
MLTSS	306,503,505	34,910,540	15,851,977	357,266,022	9,967,446	160,225	1,242,090	227,296	368,863,080
Incentive Payments	24,387,567	28,103,294	724,476	53,215,337	1,692,022	918,165	(15,063)		55,810,462
Medical Management	22,626,012	15,991,024	3,457,599	42,074,634	6,799,184	2,211,481	7,746,165	1,212,472	60,043,937
Other Medical Expenses	75,771,887	56,867,844	8,330,795	140,970,525					140,970,525
Total Medical Expenses	1,162,909,450	835,830,451	152,046,388	2,150,786,289	166,541,667	79,716,526	26,178,039	1,439,768	2,424,662,289
Medical Loss Ratio	97.9%	86.5%	85.3%	92.2%	95.0%	95.8%	90.7%	90.4%	92.5%
GROSS MARGIN	**25,010,141**	**130,687,898**	**26,146,426**	**181,844,465**	**8,765,910**	**3,457,361**	**2,697,250**	**152,500**	**196,917,487**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				73,079,526	4,185,450	2,377,675	1,087,902	599,218	81,329,771
Professional Fees				4,888,235	11,647	195,678	3,106	10,667	5,109,332
Purchased Services				7,532,187	596,518	585,654	147,943		8,862,301
Printing & Postage				2,611,607	257,725	660,582	155,448		3,685,361
Depreciation & Amortization				2,949,602			5,564		2,955,166
Other Expenses				14,086,240	9,959	9,876	80,603	47,573	14,234,251
Indirect Cost Allocation, Occupancy				(4,284,788)	4,929,832	2,477,608	111,603	43,765	3,278,020
Total Administrative Expenses				**100,862,609**	**9,991,130**	**6,307,072**	**1,592,169**	**701,222**	**119,454,202**
Admin Loss Ratio				4.3%	5.7%	7.6%	5.5%	44.0%	4.6%
INCOME (LOSS) FROM OPERATIONS				80,981,856	(1,225,220)	(2,849,711)	1,105,081	(548,722)	77,463,284
INVESTMENT INCOME									44,644,767
NET RENTAL INCOME									946,390
TOTAL MCO TAX				22,542					22,542
TOTAL GRANT EXPENSE				(22,523,672)					(22,523,672)
OTHER INCOME				60					60
CHANGE IN NET ASSETS				**$ 58,480,786**	**$ (1,225,220)**	**$ (2,849,711)**	**$ 1,105,081**	**$ (548,722)**	**$ 100,553,371**
BUDGETED CHANGE IN NET ASSETS				26,520,929	(3,012,144)	(4,558,932)	(20,572)	(344,948)	23,311,013
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,959,857	$ 1,786,924	$ 1,709,221	$ 1,125,653	$ (203,774)	$ 77,242,358

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CalOptima Health

Balance Sheet: As of February 2023

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$486,465,749	Accounts Payable	$9,060,304
Short-term Investments	1,724,564,815	Medical Claims Liability	1,671,082,183
Capitation Receivable	394,044,472	Accrued Payroll Liabilities	16,461,901
Receivables - Other	90,436,589	Deferred Revenue	7,654,113
Prepaid Expenses	25,016,588	Deferred Lease Obligations	67,790
		Capitation and Withholds	88,205,520
Total Current Assets	**2,720,528,213**	**Total Current Liabilities**	**1,792,531,811**
Capital Assets			
Furniture & Equipment	50,138,637		
Building/Leasehold Improvements	5,255,465		
Construction in Progress	5,182,508		
505 City Parkway West	52,951,401		
500 City Parkway West	22,631,500		
	136,159,511		
Less: Accumulated Depreciation	(69,029,517)	**Other Liabilities**	
Capital Assets, Net	67,129,994	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		**Other (than pensions) Post**	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,516,097
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	75,000
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,129,994		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,815,700,762**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	4,162,293		
Investments	565,766,312	**Deferred Inflows**	
Total Board-Designated Assets	569,928,605	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	570,228,605	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,357,886,812**	TNE	102,425,013
		Funds in Excess of TNE	1,417,597,126
Deferred Outflows		**TOTAL NET POSITION**	1,520,022,138
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,367,512,405**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,367,512,405**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of February 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	232,262,186				
	Tier 1 - MetLife	230,555,991				
Board-designated Reserve		462,818,177	333,066,347	519,705,501	129,751,830	(56,887,324)
	Tier 2 - Payden & Rygel	53,728,565				
	Tier 2 - MetLife	53,381,862				
TNE Requirement		107,110,427	102,425,013	102,425,013	4,685,415	4,685,415
	Consolidated:	**569,928,604**	**435,491,360**	**622,130,514**	**134,437,245**	**(52,201,909)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of February 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 2/28/2023	**$1,520.0**			**100.0%**
Resources Assigned	Board Designated Reserve*	**569.9**			**37.5%**
	Capital Assets, net of depreciation	**67.1**			**4.4%**
Resources Allocated	Homeless Health Initiative**	$23.2	$59.9	$36.7	1.5%
	Housing and Homelessness Incentive Program***	40.1	40.1	0.0	2.6%
	Intergovernmental Transfers (IGT)	61.6	111.7	50.2	4.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning Measurement Year (MY) 2023	153.5	153.5	0.0	10.1%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	1.0%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.7%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	5.0	5.0	0.0	0.3%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	1.3	2.0	0.7	0.1%
	Digital Transformation and Workplace Modernization	94.2	100.0	5.8	6.2%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.6%
	Subtotal:	**$446.9**	**$566.2**	**$119.4**	**29.4%**
Resources Available for New Initiatives	Unallocated/Unassigned*	**$436.1**			**28.7%**

*Total of Board-designated reserve and unallocated reserve amount can support approximately 101 days of CalOptima Health's current operations

**See Page 17 for Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

***On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP. Please see page 18 for project details.

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Homeless Health Initiative and Allocated Funds: As of February 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Homeless Coordination at Hospitals	10,000,000	9,197,577	802,423
Recuperative Care	6,194,190	6,194,190	-
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,913	3,170,400	6,718,514
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Days, HCAP and FQHC Administrative Support	963,261	620,719	342,542
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
FQHC (Community Health Center) Expansion	21,902	21,902	-
Medical Respite	250,000	250,000	-
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$100,000,000**	**$36,691,170**	**$63,308,830**
Transfer of funds to HHIP	(40,100,000)		(40,100,000)
Program Total	**$59,900,000**	**$36,691,170**	**$23,208,830**

*On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP. See Summary of Housing and Homelessness Incentive Program for detailed list of initiatives

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CalOptima Health

Housing and Homelessness Incentive Program As of February 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	5,000,000	-	5,000,000
Infrastructure Projects	10,500,000	-	10,500,000
Capital Projects	21,000,000	-	21,000,000
Subtotal of Approved Initiatives	**$ 40,100,000**	**$ -**	**$ 40,100,000**
Program Commitment Balance, available for new initiatives	-	-	-
Program Total	**$ 40,100,000**	**$ -**	**$ 40,100,000**

Note: On March 2, 2023, the Board of Directors approved allocation of $12.6M received from DHCS for the Housing and fnd Homelessness Incentive Program to Capital Projects. This additional funding will be included in the March report.

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UNAUDITED FINANCIAL STATEMENTS

February 28, 2023

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CalOptima Health - Consolidated
Financial Highlights
For the Eight Months Ended February 28, 2023

February					July - February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
976,552	913,151	63,401	6.9%	Member Months	7,562,378	7,305,918	256,460	3.5%
320,752,951	329,850,106	(9,097,155)	(2.8%)	Revenues	2,621,579,775	2,673,516,085	(51,936,310)	(1.9%)
287,055,217	297,363,354	10,308,137	3.5%	Medical Expenses	2,424,662,289	2,500,925,224	76,262,935	3.0%
15,108,328	18,757,199	3,648,871	19.5%	Administrative Expenses	119,454,202	142,318,218	22,864,016	16.1%
18,589,406	**13,729,553**	**4,859,853**	**35.4%**	**Operating Margin**	**77,463,284**	**30,272,643**	**47,190,641**	**155.9%**
				Non-Operating Income (Loss)				
3,596,217	500,000	3,096,217	619.2%	Net Investment Income/Expense	44,644,767	4,000,000	40,644,767	1016.1%
145,136	90,835	54,301	59.8%	Net Rental Income/Expense	946,390	726,680	219,710	30.2%
(319)	-	(319)	(100.0%)	Net MCO Tax	22,542	-	22,542	100.0%
(1,478,218)	(2,077,922)	599,704	28.9%	Grant Expense	(22,523,672)	(11,688,310)	(10,835,362)	(92.7%)
15	-	15	100.0%	Other Income/Expense	60	-	60	100.0%
2,262,831	**(1,487,087)**	**3,749,918**	**252.2%**	**Total Non-Operating Income (Loss)**	**23,090,086**	**(6,961,630)**	**30,051,716**	**431.7%**
20,852,237	**12,242,466**	**8,609,771**	**70.3%**	**Change in Net Assets**	**100,553,371**	**23,311,013**	**77,242,358**	**331.4%**
89.5%	90.2%	(0.7%)		Medical Loss Ratio	92.5%	93.5%	(1.1%)	
4.7%	5.7%	1.0%		Administrative Loss Ratio	4.6%	5.3%	0.8%	
5.8%	4.2%	1.6%		Operating Margin Ratio	3.0%	1.1%	1.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.5%	90.2%	(0.7%)		*MLR (excluding Directed Payments)	92.2%	93.5%	(1.4%)	
4.7%	5.7%	1.0%		*ALR (excluding Directed Payments)	4.8%	5.3%	0.5%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima Health
Financial Dashboard
For the Eight Months Ended February 28, 2023

February

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	958,778	895,677	63,101	7.0%
OneCare Connect	-	-	-	0.0%
OneCare	17,342	16,989	353	2.1%
PACE	432	485	(53)	(10.9%)
MSSP	472	568	(96)	(16.9%)
Total*	976,552	913,151	63,401	6.9%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 18,231	$ 11,186	7,045	63.0%
OneCare Connect	(167)	(41)	(126)	(307.3%)
OneCare	(1,416)	192	(1,608)	(837.5%)
PACE	511	354	157	44.4%
MSSP	(49)	(40)	(9)	(22.5%)
Buildings	145	91	54	59.3%
Investment Income/Expense	3,596	500	3,096	619.2%
Total	$ 20,851	$ 12,242	8,609	70.3%

MLR	Actual	Budget	% Point Var
Medi-Cal	88.6%	90.1%	(1.5)
OneCare Connect	18.9%	0.0%	18.9
OneCare	98.2%	91.0%	7.2

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 12,806	$ 16,028	$ 3,222	20.1%
OneCare Connect	88	14	(74)	(520.1%)
OneCare	1,957	2,364	407	17.2%
PACE	171	257	85	33.2%
MSSP	86	94	8	8.4%
Total	$ 15,108	$ 18,757	$ 3,649	19.5%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,208	1,323	115
OneCare Connect	17	2	(15)
OneCare	170	222	52
PACE	99	115	15
MSSP	21	23	2
Total	1,515	1,684	170

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	794	677	(117)
OneCare Connect	-	-	-
OneCare	102	77	(26)
PACE	4	4	(0)
MSSP	22	25	2
Total	645	542	(103)

July - February

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	7,420,503	7,164,388	256,115	3.6%
OneCare Connect	86,185	87,887	(1,702)	(1.9%)
OneCare	52,224	49,912	2,312	4.6%
PACE	3,466	3,731	(265)	(7.1%)
MSSP	3,778	4,544	(766)	(16.9%)
Total*	7,562,378	7,305,918	256,460	3.5%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 58,481	$ 26,521	31,960	120.5%
OneCare Connect	(1,225)	(3,012)	1,787	59.3%
OneCare	(2,850)	(4,559)	1,709	37.5%
PACE	1,105	(21)	1,126	5361.9%
MSSP	(549)	(345)	(204)	(59.1%)
Buildings	946	727	219	30.1%
Investment Income/Expense	44,645	4,000	40,645	1016.1%
Total	$ 100,553	$ 23,311	77,242	331.4%

MLR	Actual	Budget	% Point Var
Medi-Cal	92.2%	93.3%	(1.1)
OneCare Connect	95.0%	95.2%	(0.2)
OneCare	95.8%	97.0%	(1.2)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 100,863	$ 121,498	$ 20,635	17.0%
OneCare Connect	9,991	11,123	1,132	10.2%
OneCare	6,307	6,806	499	7.3%
PACE	1,592	2,113	521	24.7%
MSSP	701	777	76	9.8%
Total	$ 119,454	$ 142,318	$ 22,864	16.1%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	9,296	10,500	1,204
OneCare Connect	1,010	1,185	174
OneCare	438	590	152
PACE	762	912	150
MSSP	164	184	20
Total	11,670	13,371	1,701

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	682	(116)
OneCare Connect	85	74	(11)
OneCare	119	85	(35)
PACE	5	4	(0)
MSSP	23	25	2
Total	648	546	(102)

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended February 28, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	976,552		913,151		63,401	
REVENUE						
Medi-Cal	$ 286,350,966	$ 298.66	$ 296,915,773	$ 331.50	$ (10,564,807)	$ (33)
OneCare Connect	(96,982)	-	-	-	(96,982)	-
OneCare	30,615,833	1,765.42	28,552,861	1,680.67	2,062,972	84.75
PACE	3,673,075	8,502.49	4,127,955	8,511.25	(454,880)	(8.76)
MSSP	210,059	445.04	253,517	446.33	(43,458)	(1.29)
Total Operating Revenue	320,752,951	328.45	329,850,106	361.22	(9,097,155)	(32.77)
MEDICAL EXPENSES						
Medi-Cal	253,835,081	264.75	267,623,019	298.79	13,787,939	34.04
OneCare Connect	(18,308)	-	27,242	-	45,550	-
OneCare	30,074,430	1,734.20	25,996,180	1,530.18	(4,078,250)	(204.02)
PACE	2,990,345	6,922.09	3,517,433	7,252.44	527,088	330.35
MSSP	173,670	367.94	199,480	351.20	25,810	(16.74)
Total Medical Expenses	287,055,217	293.95	297,363,354	325.65	10,308,137	31.70
GROSS MARGIN	33,697,734	34.50	32,486,752	35.57	1,210,982	(1.07)
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	9,706,794	9.94	10,965,233	12.01	1,258,439	2.07
Professional Fees	802,172	0.82	987,567	1.08	185,395	0.26
Purchased Services	1,311,109	1.34	2,621,151	2.87	1,310,042	1.53
Printing & Postage	479,177	0.49	781,577	0.86	302,400	0.37
Depreciation & Amortization	368,412	0.38	525,900	0.58	157,488	0.20
Other Expenses	2,046,552	2.10	2,475,893	2.71	429,341	0.61
Indirect Cost Allocation, Occupancy	394,112	0.40	399,878	0.44	5,766	0.04
Total Administrative Expenses	15,108,328	15.47	18,757,199	20.54	3,648,871	5.07
INCOME (LOSS) FROM OPERATIONS	18,589,406	19.04	13,729,553	15.04	4,859,853	4.00
INVESTMENT INCOME						
Interest Income	9,038,432	9.26	500,000	0.55	8,538,432	8.71
Realized Gain/(Loss) on Investments	(877,347)	(0.90)	-	-	(877,347)	(0.90)
Unrealized Gain/(Loss) on Investments	(4,564,867)	(4.67)	-	-	(4,564,867)	(4.67)
Total Investment Income	3,596,217	3.68	500,000	0.55	3,096,217	3.13
NET RENTAL INCOME	145,136	0.15	90,835	0.10	54,301	0.05
TOTAL MCO TAX	(319)	-	-	-	(319)	-
TOTAL GRANT EXPENSE	(1,478,218)	(1.51)	(2,077,922)	(2.28)	599,704	0.77
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**20,852,237**	**21.35**	**12,242,466**	**13.41**	**8,609,771**	**7.94**
MEDICAL LOSS RATIO	**89.5%**		**90.2%**		**(0.7%)**	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**5.7%**		**1.0%**	

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CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	7,562,378		7,305,918		256,460	
REVENUE						
Medi-Cal	$ 2,332,630,754	$ 314.35	2,396,913,592	$ 334.56	$ (64,282,838)	$ (20.21)
OneCare Connect	175,307,577	2,034.08	167,628,057	1,907.31	7,679,520	126.77
OneCare	83,173,887	1,592.64	75,940,908	1,521.50	7,232,979	71.14
PACE	28,875,289	8,331.01	31,005,392	8,310.21	(2,130,103)	20.80
MSSP	1,592,269	421.46	2,028,136	446.33	(435,867)	(24.87)
Total Operating Revenue	2,621,579,775	346.66	2,673,516,085	365.94	(51,936,310)	(19.28)
MEDICAL EXPENSES						
Medi-Cal	2,150,786,289	289.84	2,237,206,492	312.27	86,420,203	22.43
OneCare Connect	166,541,667	1,932.37	159,516,706	1,815.02	(7,024,961)	(117.35)
OneCare	79,716,526	1,526.43	73,693,528	1,476.47	(6,022,998)	(49.96)
PACE	26,178,039	7,552.81	28,912,658	7,749.31	2,734,619	196.50
MSSP	1,439,768	381.09	1,595,840	351.20	156,072	(29.89)
Total Medical Expenses	2,424,662,289	320.62	2,500,925,224	342.31	76,262,935	21.69
GROSS MARGIN	196,917,487	26.04	172,590,861	23.63	24,326,626	2.41
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	81,329,771	10.75	90,042,452	12.32	8,712,681	1.57
Professional Fees	5,109,332	0.68	7,563,676	1.04	2,454,344	0.36
Purchased Services	8,862,301	1.17	12,604,357	1.73	3,742,056	0.56
Printing & Postage	3,685,361	0.49	4,414,975	0.60	729,614	0.11
Depreciation & Amortization	2,955,166	0.39	4,207,200	0.58	1,252,034	0.19
Other Expenses	14,234,251	1.88	19,529,463	2.67	5,295,212	0.79
Indirect Cost Allocation, Occupancy	3,278,020	0.43	3,956,095	0.54	678,075	0.11
Total Administrative Expenses	119,454,202	15.80	142,318,218	19.48	22,864,016	3.68
INCOME (LOSS) FROM OPERATIONS	77,463,284	10.24	30,272,643	4.14	47,190,641	6.10
INVESTMENT INCOME						
Interest Income	50,925,929	6.73	4,000,000	0.55	46,925,929	6.18
Realized Gain/(Loss) on Investments	(7,215,626)	(0.95)	-	0.00	(7,215,626)	(0.95)
Unrealized Gain/(Loss) on Investments	934,463	0.12	-	0.00	934,463	0.12
Total Investment Income	44,644,767	5.90	4,000,000	0.55	40,644,767	5.35
NET RENTAL INCOME	946,390	0.13	726,680	0.10	219,710	0.03
TOTAL MCO TAX	22,542	0.00	-	0.00	22,542	0.00
TOTAL GRANT EXPENSE	(22,523,672)	(2.98)	(11,688,310)	(1.60)	(10,835,362)	(1.38)
OTHER INCOME	60	0.00	-	0.00	60	0.00
CHANGE IN NET ASSETS	**100,553,371**	**13.30**	**23,311,013**	**3.19**	**77,242,358**	**10.11**
MEDICAL LOSS RATIO	**92.5%**		**93.5%**		**(1.1%)**	
ADMINISTRATIVE LOSS RATIO	**4.6%**		**5.3%**		**0.8%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended February 28, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	589,198	357,707	11,873	958,778		17,342	432	472	976,552
REVENUES									
Capitation Revenue	146,130,427	$ 118,568,968	$ 21,651,571	$ 286,350,966	$ (96,982)	$ 30,615,833	$ 3,673,075	$ 210,059	$ 320,752,951
Total Operating Revenue	146,130,427	118,568,968	21,651,571	286,350,966	(96,982)	30,615,833	3,673,075	210,059	320,752,951
MEDICAL EXPENSES									
Provider Capitation	44,983,511	51,773,662	7,196,355	103,953,528	126,555	13,034,914			117,114,997
Facilities	31,766,893	25,201,017	3,846,744	60,814,654	(341,046)	5,389,131	457,180		66,319,919
Professional Claims	25,807,208	14,614,556	1,447,802	41,869,566	82,948	1,251,932	1,102,304		44,306,750
Prescription Drugs	(273,976)			(273,976)	(44,994)	9,044,144	420,831		9,146,005
MLTSS	29,187,044	3,817,874	2,102,410	35,107,328	(139,301)	80,071	98,686	24,472	35,171,256
Incentive Payments	2,487,784	3,834,561	48,516	6,370,861	49,474	366,596	(52,988)		6,733,944
Medical Management	2,883,639	2,023,061	358,087	5,264,786	248,056	907,642	964,331	149,198	7,534,013
Other Medical Expenses	433,540	283,077	11,716	728,333					728,333
Total Medical Expenses	137,275,642	101,547,808	15,011,630	253,835,081	(18,308)	30,074,430	2,990,345	173,670	287,055,217
Medical Loss Ratio	93.9%	85.6%	69.3%	88.6%	18.9%	98.2%	81.4%	82.7%	89.5%
GROSS MARGIN	**8,854,784**	**17,021,160**	**6,639,941**	**32,515,885**	**(78,673)**	**541,403**	**682,730**	**36,389**	**33,697,734**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				8,738,816	27,493	735,978	132,220	72,289	9,706,794
Professional Fees				792,868	(12,863)	20,833		1,333	802,172
Purchased Services				1,062,728	74,310	159,197	14,874		1,311,109
Printing & Postage				368,859	(2,183)	110,750	1,752		479,177
Depreciation & Amortization				367,101			1,311		368,412
Other Expenses				2,027,234	1,120	4,310	7,199	6,690	2,046,552
Indirect Cost Allocation, Occupancy				(551,240)		925,930	13,950	5,471	394,112
Total Administrative Expenses				**12,806,365**	**87,878**	**1,956,997**	**171,306**	**85,783**	**15,108,328**
Admin Loss Ratio				4.5%	-90.6%	6.4%	4.7%	40.8%	4.7%
INCOME (LOSS) FROM OPERATIONS				19,709,520	(166,551)	(1,415,594)	511,424	(49,393)	18,589,406
INVESTMENT INCOME									3,596,217
NET RENTAL INCOME									145,136
TOTAL MCO TAX				(319)					(319)
TOTAL GRANT EXPENSE				(1,478,218)					(1,478,218)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ 18,230,998**	**$ (166,551)**	**$ (1,415,594)**	**$ 511,424**	**$ (49,393)**	**$ 20,852,237**
BUDGETED CHANGE IN NET ASSETS				11,186,459	(41,413)	192,248	353,994	(39,657)	12,242,466
VARIANCE TO BUDGET - FAV (UNFAV)				$ 7,044,539	$ (125,138)	$ (1,607,842)	$ 157,430	$ (9,736)	$ 8,609,771

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eight Months Ended February 28, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	4,574,800	2,751,062	94,641	7,420,503	86,185	52,224	3,466	3,778	7,562,378
REVENUES									
Capitation Revenue	1,187,919,592	$ 966,518,348	$ 178,192,814	$ 2,332,630,754	$ 175,307,577	$ 83,173,887	$ 28,875,289	$ 1,592,269	$ 2,621,579,775
Total Operating Revenue	1,187,919,592	966,518,348	178,192,814	2,332,630,754	175,307,577	83,173,887	28,875,289	1,592,269	2,621,579,775
MEDICAL EXPENSES									
Provider Capitation	296,020,532	363,427,825	69,281,116	728,729,474	72,131,559	31,590,961			832,451,993
Facilities	258,312,973	226,095,175	42,874,156	527,282,303	27,166,699	15,469,246	6,500,603		576,418,852
Professional Claims	181,584,986	112,721,821	11,520,664	305,827,471	8,749,963	3,517,946	7,487,395		325,582,776
Prescription Drugs	(2,298,011)	(2,287,072)	5,604	(4,579,479)	40,034,793	25,848,502	3,216,848		64,520,664
MLTSS	306,503,505	34,910,540	15,851,977	357,266,022	9,967,446	160,225	1,242,090	227,296	368,863,080
Incentive Payments	24,387,567	28,103,294	724,476	53,215,337	1,692,022	918,165	(15,063)		55,810,462
Medical Management	22,626,012	15,991,024	3,457,599	42,074,634	6,799,184	2,211,481	7,746,165	1,212,472	60,043,937
Other Medical Expenses	75,771,887	56,867,844	8,330,795	140,970,525					140,970,525
Total Medical Expenses	1,162,909,450	835,830,451	152,046,388	2,150,786,289	166,541,667	79,716,526	26,178,039	1,439,768	2,424,662,289
Medical Loss Ratio	97.9%	86.5%	85.3%	92.2%	95.0%	95.8%	90.7%	90.4%	92.5%
GROSS MARGIN	**25,010,141**	**130,687,898**	**26,146,426**	**181,844,465**	**8,765,910**	**3,457,361**	**2,697,250**	**152,500**	**196,917,487**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				73,079,526	4,185,450	2,377,675	1,087,902	599,218	81,329,771
Professional Fees				4,888,235	11,647	195,678	3,106	10,667	5,109,332
Purchased Services				7,532,187	596,518	585,654	147,943		8,862,301
Printing & Postage				2,611,607	257,725	660,582	155,448		3,685,361
Depreciation & Amortization				2,949,602			5,564		2,955,166
Other Expenses				14,086,240	9,959	9,876	80,603	47,573	14,234,251
Indirect Cost Allocation, Occupancy				(4,284,788)	4,929,832	2,477,608	111,603	43,765	3,278,020
Total Administrative Expenses				**100,862,609**	**9,991,130**	**6,307,072**	**1,592,169**	**701,222**	**119,454,202**
Admin Loss Ratio				4.3%	5.7%	7.6%	5.5%	44.0%	4.6%
INCOME (LOSS) FROM OPERATIONS				80,981,856	(1,225,220)	(2,849,711)	1,105,081	(548,722)	77,463,284
INVESTMENT INCOME									44,644,767
NET RENTAL INCOME									946,390
TOTAL MCO TAX				22,542					22,542
TOTAL GRANT EXPENSE				(22,523,672)					(22,523,672)
OTHER INCOME				60					60
CHANGE IN NET ASSETS				**$ 58,480,786**	**$ (1,225,220)**	**$ (2,849,711)**	**$ 1,105,081**	**$ (548,722)**	**$ 100,553,371**
BUDGETED CHANGE IN NET ASSETS				26,520,929	(3,012,144)	(4,558,932)	(20,572)	(344,948)	23,311,013
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,959,857	$ 1,786,924	$ 1,709,221	$ 1,125,653	$ (203,774)	$ 77,242,358

Note:* Total membership does not include MSSP

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CalOptima Health

February 28, 2023 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $20.9 million, $8.6 million favorable to budget
- Operating surplus is $18.6 million, with a surplus in non-operating income of $2.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $100.6 million, $77.2 million favorable to budget
- Operating surplus is $77.5 million, with a surplus in non-operating income of $23.1 million

Change in Net Assets by Line of Business (LOB) ($ millions):

February				July-February		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
19.7	13.3	6.4	Medi-Cal	81.0	38.2	42.8
(0.2)	(0.0)	(0.1)	OCC	(1.2)	(3.0)	1.8
(1.4)	0.2	(1.6)	OneCare	(2.8)	(4.6)	1.7
0.5	0.4	0.2	PACE	1.1	(0.0)	1.1
(0.0)	(0.0)	(0.0)	MSSP	(0.5)	(0.3)	(0.2)
18.6	**13.7**	**4.9**	**Total Operating Income (Loss)**	**77.5**	**30.3**	**47.2**
			Non-Operating Income (Loss)			
3.6	0.5	3.1	Net Investment Income/Expense	44.6	4.0	40.6
0.1	0.1	0.1	Net Rental Income/Expense	0.9	0.7	0.2
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(1.5)	(2.1)	0.6	Grant Expense	(22.5)	(11.7)	(10.8)
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
2.3	**(1.5)**	**3.7**	**Total Non-Operating Income/(Loss)**	**23.1**	**(7.0)**	**30.1**
20.9	**12.2**	**8.6**	**TOTAL**	**100.6**	**23.3**	**77.2**

CalOptima Health - Consolidated
Enrollment Summary
For the Eight Months Ended February 28, 2023

February					July - February			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
138,256	138,273	(17)	(0.0%)	SPD	1,030,545	1,012,331	18,214	1.8%
305,476	303,842	1,634	0.5%	TANF Child	2,431,598	2,445,234	(13,636)	(0.6%)
142,354	130,035	12,319	9.5%	TANF Adult	1,086,747	1,069,692	17,055	1.6%
3,112	3,483	(371)	(10.7%)	LTC	25,910	26,968	(1,058)	(3.9%)
357,707	308,205	49,502	16.1%	MCE	2,751,062	2,515,943	235,119	9.3%
11,873	11,839	34	0.3%	WCM	94,641	94,220	421	0.4%
958,778	**895,677**	**63,101**	**7.0%**	**Medi-Cal Total**	**7,420,503**	**7,164,388**	**256,115**	**3.6%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,342	**16,989**	**353**	**2.1%**	**OneCare**	**52,224**	**49,912**	**2,312**	**4.6%**
432	**485**	**(53)**	**(10.9%)**	**PACE**	**3,466**	**3,731**	**(265)**	**(7.1%)**
472	**568**	**(96)**	**(16.9%)**	**MSSP**	**3,778**	**4,544**	**(766)**	**(16.9%)**
976,552	**913,151**	**63,401**	**6.9%**	**CalOptima Total**	**7,562,378**	**7,305,918**	**256,460**	**3.5%**
				Enrollment (by Network)				
267,158	206,255	60,903	29.5%	HMO	1,904,480	1,678,328	226,152	13.5%
192,472	235,873	(43,401)	(18.4%)	PHC	1,716,280	1,905,946	(189,666)	(10.0%)
232,511	217,527	14,984	6.9%	Shared Risk Group	1,824,784	1,766,816	57,968	3.3%
266,637	236,022	30,615	13.0%	Fee for Service	1,974,959	1,813,298	161,661	8.9%
958,778	**895,677**	**63,101**	**7.0%**	**Medi-Cal Total**	**7,420,503**	**7,164,388**	**256,115**	**3.6%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,342	**16,989**	**353**	**2.1%**	**OneCare**	**52,224**	**49,912**	**2,312**	**4.6%**
432	**485**	**(53)**	**(10.9%)**	**PACE**	**3,466**	**3,731**	**(265)**	**(7.1%)**
472	**568**	**(96)**	**(16.9%)**	**MSSP**	**3,778**	**4,544**	**(766)**	**(16.9%)**
976,552	**913,151**	**63,401**	**6.9%**	**CalOptima Total**	**7,562,378**	**7,305,918**	**256,460**	**3.5%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288	14,002	14,044	14,044	14,090					101,245	87,834	13,411
TANF Child	58,966	58,892	58,837	58,847	69,892	69,736	69,972	70,036					515,178	473,792	41,386
TANF Adult	38,926	38,983	39,331	39,640	48,530	48,844	49,255	49,567					353,076	331,590	21,486
LTC	1	2	2	1				1					7		7
MCE	99,022	99,788	100,301	101,292	127,939	128,438	129,823	131,179					917,782	768,157	149,625
WCM	2,034	2,020	2,021	2,050	2,272	2,268	2,242	2,285					17,192	16,955	237
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**	**263,330**	**265,336**	**267,158**					**1,904,480**	**1,678,328**	**226,152**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408	4,387	4,435	4,356					45,714	55,962	(10,248)
TANF Child	158,385	158,345	158,767	159,067	148,298	148,419	148,820	149,257					1,229,358	1,275,357	(45,999)
TANF Adult	16,704	16,780	16,830	16,855	8,478	8,499	8,550	8,590					101,286	139,613	(38,327)
LTC		1	1	3		2							7		7
MCE	47,505	47,574	47,748	48,051	22,411	22,545	22,920	23,161					281,915	376,938	(95,023)
WCM	7,366	7,472	7,340	7,301	7,096	7,142	7,175	7,108					58,000	58,076	(76)
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**	**190,994**	**191,900**	**192,472**					**1,716,280**	**1,905,946**	**(189,666)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023	11,046	11,181	11,053					88,004	81,544	6,460
TANF Child	57,419	57,075	56,762	56,460	56,201	55,828	55,913	55,869					451,527	478,195	(26,668)
TANF Adult	40,518	40,260	40,370	40,566	40,961	41,218	41,636	42,055					327,584	323,852	3,732
LTC	2	1	3	6	2								14		14
MCE	114,819	115,585	116,539	117,839	118,935	119,808	121,272	122,217					947,014	872,081	74,933
WCM	1,360	1,341	1,332	1,369	1,325	1,303	1,294	1,317					10,641	11,144	(503)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**	**229,203**	**231,296**	**232,511**					**1,824,784**	**1,766,816**	**57,968**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174	83,819	98,278	98,465					696,238	696,491	(253)
TANF Child	1	1	1	1	1	1	1	1					8		8
TANF Adult	1,675	1,712	1,743	1,742	1,767	1,776	2,271	2,318					15,004	15,438	(434)
LTC	2,894	2,874	2,845	2,879	2,929	2,915	2,943	2,745					23,024	24,296	(1,272)
MCE	6,480	6,749	7,030	7,314	7,498	7,795	8,014	8,269					59,149	45,201	13,948
WCM	20	18	24	17	16	18	14	16					143	122	21
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**	**96,324**	**111,521**	**111,814**					**793,566**	**781,548**	**12,018**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224	12,480	15,537	10,292					99,344	90,500	8,844
TANF Child	28,613	28,702	29,350	29,540	30,022	28,970	30,017	30,313					235,527	217,890	17,637
TANF Adult	32,830	33,442	37,388	38,818	35,106	35,368	37,021	39,824					289,797	259,199	30,598
LTC	360	364	366	345	344	346	367	366					2,858	2,672	186
MCE	63,450	64,657	66,876	67,538	69,063	69,002	71,735	72,881					545,202	453,566	91,636
WCM	1,096	1,094	1,049	1,080	1,036	1,069	1,094	1,147					8,665	7,923	742
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**	**147,235**	**155,771**	**154,823**					**1,181,393**	**1,031,750**	**149,643**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831	125,776	143,475	138,256					1,030,545	1,012,331	18,214
TANF Child	303,384	303,015	303,717	303,915	304,414	302,954	304,723	305,476					2,431,598	2,445,234	(13,636)
TANF Adult	130,653	131,177	135,662	137,621	134,842	135,705	138,733	142,354					1,086,747	1,069,692	17,055
LTC	3,257	3,242	3,217	3,234	3,275	3,263	3,310	3,112					25,910	26,968	(1,058)
MCE	331,276	334,353	338,494	342,034	345,846	347,588	353,764	357,707					2,751,062	2,515,943	235,119
WCM	11,876	11,945	11,766	11,817	11,745	11,800	11,819	11,873					94,641	94,220	421
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**	**927,086**	**955,824**	**958,778**					**7,420,503**	**7,164,388**	**256,115**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**	**14,385**	**26**	**0**					**86,185**	**87,887**	**(1,702)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**	**3,067**	**17,293**	**17,342**					**52,224**	**49,912**	**2,312**
PACE	**435**	**434**	**437**	**430**	**433**	**437**	**428**	**432**					**3,466**	**3,731**	**(265)**
MSSP	**466**	**470**	**478**	**478**	**476**	**471**	**467**	**472**					**3,778**	**4,544**	**(766)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**	**944,975**	**973,571**	**976,552**					**7,562,378**	**7,305,918**	**256,460**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, February enrollment was 976,552

- Favorable to budget 63,401 or 6.9%
- Increased 2,981 or 0.3% from Prior Month (PM) (January 2023)
- Increased 94,551 or 10.7% from Prior Year (PY) (February 2022)

Medi-Cal enrollment was 958,778

- Favorable to budget 63,101 or 7.0% as the Department of Health Care Services (DHCS) pauses Medi-Cal redetermination due to the extension of the Public Health Emergency
  - Medi-Cal Expansion (MCE) favorable 49,502
  - Temporary Assistance for Needy Families (TANF) favorable 13,953
  - Whole Child Model (WCM) favorable 34
  - Long-Term Care (LTC) unfavorable 371
  - Seniors and Persons with Disabilities (SPD) unfavorable 17
- Increased 2,954 from PM

OneCare enrollment was 17,342

- Favorable to budget 353 or 2.1%
- Increased 49 from PM

OneCare Connect enrollment was 0 due to transition of OCC members to OC, effective January 1, 2023

- Decreased 26 from PM due to retroactive members in January

PACE enrollment was 432

- Unfavorable to budget 53 or 10.9%
- Increased 4 from PM

MSSP enrollment was 472

- Unfavorable to budget 96 or 16.9% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Increased 5 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
958,778	**895,677**	**63,101**	**7.0%**	**Member Months**	**7,420,503**	**7,164,388**	**256,115**	**3.6%**
				Revenues				
286,350,966	296,915,773	(10,564,807)	(3.6%)	Medi-Cal Capitation Revenue	2,332,630,754	2,396,913,592	(64,282,838)	(2.7%)
286,350,966	**296,915,773**	**(10,564,807)**	**(3.6%)**	**Total Operating Revenue**	**2,332,630,754**	**2,396,913,592**	**(64,282,838)**	**(2.7%)**
				Medical Expenses				
103,953,528	104,346,202	392,674	0.4%	Provider Capitation	728,729,474	847,019,692	118,290,218	14.0%
60,814,654	63,149,633	2,334,979	3.7%	Facilities Claims	527,282,303	540,849,082	13,566,779	2.5%
41,869,566	39,005,521	(2,864,045)	(7.3%)	Professional Claims	305,827,471	322,989,654	17,162,183	5.3%
35,107,328	48,607,056	13,499,728	27.8%	MLTSS	357,266,022	400,088,911	42,822,889	10.7%
(273,976)	-	273,976	100.0%	Prescription Drugs	(4,579,479)	-	4,579,479	100.0%
6,370,861	4,625,318	(1,745,543)	(37.7%)	Incentive Payments	53,215,337	37,353,220	(15,862,117)	(42.5%)
5,264,786	6,315,217	1,050,431	16.6%	Medical Management	42,074,634	53,813,358	11,738,724	21.8%
728,333	1,574,072	845,739	53.7%	Other Medical Expenses	140,970,525	35,092,575	(105,877,950)	(301.7%)
253,835,081	**267,623,019**	**13,787,939**	**5.2%**	**Total Medical Expenses**	**2,150,786,289**	**2,237,206,492**	**86,420,203**	**3.9%**
32,515,885	**29,292,754**	**3,223,131**	**11.0%**	**Gross Margin**	**181,844,465**	**159,707,100**	**22,137,365**	**13.9%**
				Administrative Expenses				
8,738,816	9,709,114	970,298	10.0%	Salaries, Wages & Employee Benefits	73,079,526	79,503,033	6,423,507	8.1%
792,868	935,239	142,371	15.2%	Professional Fees	4,888,235	7,192,052	2,303,817	32.0%
1,062,728	2,166,513	1,103,785	50.9%	Purchased Services	7,532,187	10,636,460	3,104,273	29.2%
368,859	567,740	198,881	35.0%	Printing & Postage	2,611,607	3,254,954	643,347	19.8%
367,101	525,000	157,899	30.1%	Depreciation & Amortization	2,949,602	4,200,000	1,250,398	29.8%
2,027,234	2,450,427	423,193	17.3%	Other Operating Expenses	14,086,240	19,316,642	5,230,402	27.1%
(551,240)	(325,660)	225,580	69.3%	Indirect Cost Allocation, Occupancy	(4,284,788)	(2,605,280)	1,679,508	64.5%
12,806,365	**16,028,373**	**3,222,008**	**20.1%**	**Total Administrative Expenses**	**100,862,609**	**121,497,861**	**20,635,252**	**17.0%**
				Non-Operating Income (Loss)				
(319)	-	(319)	(100.0%)	Net Operating Tax	22,542	-	22,542	100.0%
(1,478,218)	(2,077,922)	599,704	28.9%	Grant Expense	(22,523,672)	(11,688,310)	(10,835,362)	(92.7%)
15	-	15	100.0%	Other Income	60	-	60	100.0%
(1,478,521)	**(2,077,922)**	**599,401**	**28.8%**	**Total Non-Operating Income (Loss)**	**(22,501,070)**	**(11,688,310)**	**(10,812,760)**	**(92.5%)**
18,230,998	**11,186,459**	**7,044,539**	**63.0%**	**Change in Net Assets**	**58,480,786**	**26,520,929**	**31,959,857**	**120.5%**
88.6%	***90.1%***	***(1.5%)***		***Medical Loss Ratio***	***92.2%***	***93.3%***	***(1.1%)***	
4.5%	***5.4%***	***0.9%***		***Admin Loss Ratio***	***4.3%***	***5.1%***	***0.7%***	

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MEDI-CAL INCOME STATEMENT– FEBRUARY MONTH:

REVENUES of $286.4 million are unfavorable to budget $10.6 million driven by:

- Favorable volume related variance of $20.9 million
- Unfavorable price related variance of $31.5 million
  - $51.1 million due to COVID-19 and Proposition 56 risk corridor reserves
  - Offset by:
    - $12.6 million due California Housing and Homelessness Incentive Program (HHIP)
    - $12.2 million due to PY retroactive eligibility changes and favorable premium capitation rates

MEDICAL EXPENSES of $253.8 million are favorable to budget $13.8 million driven by:

- Unfavorable volume related variance of $18.9 million
- Favorable price related variance of $32.7 million
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $16.9 million due to low utilization and Incurred But Not Reported (IBNR) claims
  - Provider Capitation expense favorable variance of $7.7 million due to Proposition 56 estimates
  - Facilities Claims expense favorable variance of $6.8 million due to IBNR claims
  - All other expenses net favorable variance of $1.2 million

ADMINISTRATIVE EXPENSES of $12.8 million are favorable to budget $3.2 million driven by:

- Other Non-Salary expense favorable to budget $2.3 million
- Salaries & Benefit expense favorable to budget $1.0 million

CHANGE IN NET ASSETS is $18.2 million, favorable to budget $7.0 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,342	**16,989**	**353**	**2.1%**	**Member Months**	**52,224**	**49,912**	**2,312**	**4.6%**
				Revenues				
23,181,292	21,622,436	1,558,856	7.2%	Medicare Part C Revenue	60,511,239	55,799,745	4,711,494	8.4%
7,434,540	6,930,425	504,115	7.3%	Medicare Part D Revenue	22,662,648	20,141,163	2,521,485	12.5%
30,615,833	**28,552,861**	**2,062,972**	**7.2%**	**Total Operating Revenue**	**83,173,887**	**75,940,908**	**7,232,979**	**9.5%**
				Medical Expenses				
13,034,914	11,057,411	(1,977,503)	(17.9%)	Provider Capitation	31,590,961	26,748,852	(4,842,109)	(18.1%)
5,389,131	4,365,533	(1,023,598)	(23.4%)	Inpatient	15,469,246	16,567,136	1,097,890	6.6%
1,251,932	1,041,361	(210,571)	(20.2%)	Ancillary	3,517,946	2,761,485	(756,461)	(27.4%)
80,071	71,526	(8,545)	(11.9%)	MLTSS	160,225	143,075	(17,150)	(12.0%)
9,044,144	7,292,944	(1,751,200)	(24.0%)	Prescription Drugs	25,848,502	22,357,447	(3,491,055)	(15.6%)
366,596	834,445	467,849	56.1%	Incentive Payments	918,165	1,617,695	699,530	43.2%
907,642	1,332,960	425,318	31.9%	Medical Management	2,211,481	3,497,838	1,286,357	36.8%
30,074,430	**25,996,180**	**(4,078,250)**	**(15.7%)**	**Total Medical Expenses**	**79,716,526**	**73,693,528**	**(6,022,998)**	**(8.2%)**
541,403	**2,556,681**	**(2,015,278)**	**(78.8%)**	**Gross Margin**	**3,457,361**	**2,247,380**	**1,209,981**	**53.8%**
				Administrative Expenses				
735,978	997,148	261,170	26.2%	Salaries, Wages & Employee Benefits	2,377,675	2,923,474	545,799	18.7%
20,833	40,583	19,750	48.7%	Professional Fees	195,678	222,664	26,986	12.1%
159,197	401,292	242,095	60.3%	Purchased Services	585,654	915,492	329,838	36.0%
110,750	203,268	92,518	45.5%	Printing & Postage	660,582	638,388	(22,194)	(3.5%)
4,310	16,242	11,933	73.5%	Other Operating Expenses	9,876	32,484	22,608	69.6%
925,930	705,900	(220,030)	(31.2%)	Indirect Cost Allocation, Occupancy	2,477,608	2,073,810	(403,798)	(19.5%)
1,956,997	**2,364,433**	**407,436**	**17.2%**	**Total Administrative Expenses**	**6,307,072**	**6,806,312**	**499,240**	**7.3%**
(1,415,594)	**192,248**	**(1,607,842)**	**(836.3%)**	**Change in Net Assets**	**(2,849,711)**	**(4,558,932)**	**1,709,221**	**37.5%**
98.2%	***91.0%***	***7.2%***		***Medical Loss Ratio***	***95.8%***	***97.0%***	***(1.2%)***	
6.4%	***8.3%***	***1.9%***		***Admin Loss Ratio***	***7.6%***	***9.0%***	***1.4%***	

ONECARE INCOME STATEMENT– FEBRUARY MONTH:

REVENUES of $30.6 million are favorable to budget $2.1 million driven by:

- Favorable volume related variance of $0.6 million
- Favorable price related variance of $1.5 million

MEDICAL EXPENSES of $30.1 million are unfavorable to budget $4.1 million driven by:

- Unfavorable volume related variance of $0.5 million
- Unfavorable price related variance of $3.5 million
  - Provider Capitation expense unfavorable variance of $1.7 million
  - Prescription Drugs expense unfavorable variance of $1.6 million
  - All other expenses net unfavorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $2.0 million are favorable to budget $0.4 million driven by:

- Salaries & Benefit expense favorable to budget $0.3 million
- Other Non-Salary expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($1.4) million, unfavorable to budget $1.6 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Eight Months Ending February 28, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
				Revenues				
12,999	-	12,999	100.0%	Medi-Cal Revenue	16,160,393	16,971,109	(810,716)	(4.8%)
71,659	-	71,659	100.0%	Medicare Part C Revenue	121,331,695	117,560,580	3,771,115	3.2%
(181,640)	-	(181,640)	(100.0%)	Medicare Part D Revenue	37,815,489	33,096,368	4,719,121	14.3%
(96,982)	**-**	**(96,982)**	**(100.0%)**	**Total Operating Revenue**	**175,307,577**	**167,628,057**	**7,679,520**	**4.6%**
				Medical Expenses				
126,555	-	(126,555)	(100.0%)	Provider Capitation	72,131,559	69,401,413	(2,730,146)	(3.9%)
(341,046)	-	341,046	100.0%	Facilities Claims	27,166,699	24,684,406	(2,482,293)	(10.1%)
82,948	-	(82,948)	(100.0%)	Ancillary	8,749,963	7,214,705	(1,535,258)	(21.3%)
(139,301)	-	139,301	100.0%	MLTSS	9,967,446	8,924,314	(1,043,132)	(11.7%)
(44,994)	-	44,994	100.0%	Prescription Drugs	40,034,793	38,194,494	(1,840,299)	(4.8%)
49,474	-	(49,474)	(100.0%)	Incentive Payments	1,692,022	3,304,554	1,612,532	48.8%
248,056	27,242	(220,814)	(810.6%)	Medical Management	6,799,184	7,792,820	993,636	12.8%
(18,308)	**27,242**	**45,550**	**167.2%**	**Total Medical Expenses**	**166,541,667**	**159,516,706**	**(7,024,961)**	**(4.4%)**
(78,673)	**(27,242)**	**(51,431)**	**(188.8%)**	**Gross Margin**	**8,765,910**	**8,111,351**	**654,559**	**8.1%**
				Administrative Expenses				
27,493	14,171	(13,322)	(94.0%)	Salaries, Wages & Employee Benefits	4,185,450	5,566,110	1,380,660	24.8%
(12,863)	-	12,863	100.0%	Professional Fees	11,647	124,998	113,351	90.7%
74,310	9,666	(64,644)	(668.8%)	Purchased Services	596,518	702,967	106,449	15.1%
(2,183)	(9,666)	(7,483)	(77.4%)	Printing & Postage	257,725	359,759	102,034	28.4%
1,120	-	(1,120)	(100.0%)	Other Operating Expenses	9,959	36,561	26,602	72.8%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	4,929,832	4,333,100	(596,732)	(13.8%)
87,878	**14,171**	**(73,707)**	**(520.1%)**	**Total Administrative Expenses**	**9,991,130**	**11,123,495**	**1,132,365**	**10.2%**
(166,551)	**(41,413)**	**(125,138)**	**(302.2%)**	**Change in Net Assets**	**(1,225,220)**	**(3,012,144)**	**1,786,924**	**59.3%**
18.9%	***0.0%***	***18.9%***		***Medical Loss Ratio***	***95.0%***	***95.2%***	***(0.2%)***	
(90.6%)	***0.0%***	***90.6%***		***Admin Loss Ratio***	***5.7%***	***6.6%***	***0.9%***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
432	**485**	(53)	(10.9%)	**Member Months**	**3,466**	**3,731**	**(265)**	**(7.1%)**
				Revenues				
2,787,177	3,124,243	(337,066)	(10.8%)	Medi-Cal Capitation Revenue	22,311,095	23,771,140	(1,460,045)	(6.1%)
688,329	797,347	(109,018)	(13.7%)	Medicare Part C Revenue	4,924,665	5,646,832	(722,167)	(12.8%)
197,570	206,365	(8,795)	(4.3%)	Medicare Part D Revenue	1,639,529	1,587,420	52,109	3.3%
3,673,075	**4,127,955**	**(454,880)**	**(11.0%)**	**Total Operating Revenue**	**28,875,289**	**31,005,392**	**(2,130,103)**	**(6.9%)**
				Medical Expenses				
964,331	1,089,569	125,238	11.5%	Medical Management	7,746,165	8,956,654	1,210,489	13.5%
457,180	891,274	434,094	48.7%	Facilities Claims	6,500,603	7,337,471	836,868	11.4%
920,904	896,628	(24,276)	(2.7%)	Professional Claims	6,142,198	7,377,166	1,234,968	16.7%
420,831	384,655	(36,176)	(9.4%)	Prescription Drugs	3,216,848	3,143,471	(73,377)	(2.3%)
98,686	68,406	(30,280)	(44.3%)	MLTSS	1,242,090	540,663	(701,427)	(129.7%)
181,400	181,324	(76)	(0.0%)	Patient Transportation	1,345,198	1,510,711	165,513	11.0%
(52,988)	5,577	58,565	1050.1%	Incentive Payments	(15,063)	46,522	61,585	132.4%
2,990,345	**3,517,433**	**527,088**	**15.0%**	**Total Medical Expenses**	**26,178,039**	**28,912,658**	**2,734,619**	**9.5%**
682,730	**610,522**	**72,208**	**11.8%**	**Gross Margin**	**2,697,250**	**2,092,734**	**604,516**	**28.9%**
				Administrative Expenses				
132,220	168,139	35,919	21.4%	Salaries, Wages & Employee Benefits	1,087,902	1,408,847	320,945	22.8%
-	10,412	10,412	100.0%	Professional Fees	3,106	13,298	10,192	76.6%
14,874	43,680	28,806	65.9%	Purchased Services	147,943	349,438	201,495	57.7%
1,752	20,235	18,483	91.3%	Printing & Postage	155,448	161,874	6,426	4.0%
1,311	900	(411)	(45.6%)	Depreciation & Amortization	5,564	7,200	1,636	22.7%
7,199	74	(7,125)	(9628.0%)	Other Operating Expenses	80,603	70,584	(10,019)	(14.2%)
13,950	13,088	(862)	(6.6%)	Indirect Cost Allocation, Occupancy	111,603	102,065	(9,538)	(9.3%)
171,306	**256,528**	**85,222**	**33.2%**	**Total Administrative Expenses**	**1,592,169**	**2,113,306**	**521,137**	**24.7%**
511,424	**353,994**	**157,430**	**44.5%**	**Change in Net Assets**	**1,105,081**	**(20,572)**	**1,125,653**	**5471.8%**
81.4%	***85.2%***	***(3.8%)***		***Medical Loss Ratio***	***90.7%***	***93.3%***	***(2.6%)***	
4.7%	***6.2%***	***1.6%***		***Admin Loss Ratio***	***5.5%***	***6.8%***	***1.3%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
472	**568**	**(96)**	**(16.9%)**	**Member Months**	**3,778**	**4,544**	**(766)**	**(16.9%)**
				Revenues				
210,059	253,517	(43,458)	(17.1%)	Revenue	1,592,269	2,028,136	(435,867)	(21.5%)
210,059	**253,517**	**(43,458)**	**(17.1%)**	**Total Operating Revenue**	**1,592,269**	**2,028,136**	**(435,867)**	**(21.5%)**
				Medical Expenses				
149,198	166,522	17,324	10.4%	Medical Management	1,212,472	1,332,176	119,704	9.0%
24,472	32,958	8,486	25.7%	Waiver Services	227,296	263,664	36,368	13.8%
149,198	166,522	17,324	10.4%	Total Medical Management	1,212,472	1,332,176	119,704	9.0%
24,472	32,958	8,486	25.7%	Total Waiver Services	227,296	263,664	36,368	13.8%
173,670	**199,480**	**25,810**	**12.9%**	**Total Program Expenses**	**1,439,768**	**1,595,840**	**156,072**	**9.8%**
36,389	**54,037**	**(17,648)**	**(32.7%)**	**Gross Margin**	**152,500**	**432,296**	**(279,796)**	**(64.7%)**
				Administrative Expenses				
72,289	76,661	4,372	5.7%	Salaries, Wages & Employee Benefits	599,218	640,988	41,770	6.5%
1,333	1,333	(0)	(0.0%)	Professional Fees	10,667	10,664	(3)	(0.0%)
6,690	9,150	2,460	26.9%	Other Operating Expenses	47,573	73,192	25,620	35.0%
5,471	6,550	1,079	16.5%	Indirect Cost Allocation, Occupancy	43,765	52,400	8,635	16.5%
85,783	**93,694**	**7,911**	**8.4%**	**Total Administrative Expenses**	**701,222**	**777,244**	**76,022**	**9.8%**
(49,393)	**(39,657)**	**(9,736)**	**(24.6%)**	**Change in Net Assets**	**(548,722)**	**(344,948)**	**(203,774)**	**(59.1%)**
82.7%	***78.7%***	***4.0%***		***Medical Loss Ratio***	***90.4%***	***78.7%***	***11.7%***	
40.8%	***37.0%***	***(3.9%)***		***Admin Loss Ratio***	***44.0%***	***38.3%***	***(5.7%)***	

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CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2023

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				
53,244	55,650	2,406	4.3%	Purchased Services	332,095	445,200	113,105	25.4%
208,693	224,250	15,557	6.9%	Depreciation & Amortization	1,685,963	1,794,000	108,037	6.0%
20,875	22,500	1,625	7.2%	Insurance Expense	167,000	180,000	13,000	7.2%
95,834	138,755	42,921	30.9%	Repair & Maintenance	1,012,277	1,110,040	97,763	8.8%
71,544	48,405	(23,139)	(47.8%)	Other Operating Expenses	499,170	387,240	(111,930)	(28.9%)
(450,189)	(489,560)	(39,371)	(8.0%)	Indirect Cost Allocation, Occupancy	(3,696,505)	(3,916,480)	(219,975)	(5.6%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
181,333	172,500	8,833	5.1%	Rental Income	1,463,416	1,380,000	83,416	6.0%
181,333	**172,500**	**8,833**	**5.1%**	**Total Operating Revenue**	**1,463,416**	**1,380,000**	**83,416**	**6.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
12,593	13,333	740	5.6%	Purchased Services	101,261	106,664	5,403	5.1%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
-	2,733	2,733	100.0%	Insurance Expense	-	21,864	21,864	100.0%
9,556	25,666	16,110	62.8%	Repair & Maintenance	246,230	205,328	(40,902)	(19.9%)
14,048	39,933	25,885	64.8%	Other Operating Expenses	169,535	319,464	149,929	46.9%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
36,197	**81,665**	**45,468**	**55.7%**	**Total Administrative Expenses**	**517,026**	**653,320**	**136,294**	**20.9%**
145,136	**90,835**	**54,301**	**59.8%**	**Change in Net Assets**	**946,390**	**726,680**	**219,710**	**30.2%**

OTHER INCOME STATEMENTS – FEBRUARY MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.2) million, unfavorable to budget $0.1 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.5 million, favorable to budget $0.2 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($49,393), unfavorable to budget $9,736

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $145,136, favorable to budget $54,301

- Net of $181,333 in rental income and $36,197 in expenses for the month of February

INVESTMENT INCOME

- Favorable variance of $3.1 million is due to interest income of $8.5 million and $5.4 million of losses from investments

CalOptima Health
Balance Sheet
February 28, 2023

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$486,465,749	Accounts Payable	$9,060,304
Short-term Investments	1,724,564,815	Medical Claims Liability	1,671,082,183
Capitation Receivable	394,044,472	Accrued Payroll Liabilities	16,461,901
Receivables - Other	90,436,589	Deferred Revenue	7,654,113
Prepaid Expenses	25,016,588	Deferred Lease Obligations	67,790
		Capitation and Withholds	88,205,520
Total Current Assets	**2,720,528,213**	**Total Current Liabilities**	**1,792,531,811**
Capital Assets			
Furniture & Equipment	50,138,637		
Building/Leasehold Improvements	5,255,465		
Construction in Progress	5,182,508		
505 City Parkway West	52,951,401		
500 City Parkway West	22,631,500		
	136,159,511		
Less: Accumulated Depreciation	(69,029,517)	Other Liabilities	
Capital Assets, Net	67,129,994	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,516,097
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	75,000
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,129,994		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,815,700,762**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	4,162,293		
Investments	565,766,312	Deferred Inflows	
Total Board-Designated Assets	569,928,605	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	570,228,605	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,357,886,812**	TNE	102,425,013
Deferred Outflows		Funds in Excess of TNE	1,417,597,126
Contributions	1,931,845	**TOTAL NET POSITION**	1,520,022,138
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,367,512,405**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,367,512,405**

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CalOptima Health
Board Designated Reserve and TNE Analysis
as of February 28, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	232,262,186				
	Tier 1 - MetLife	230,555,991				
Board-designated Reserve		462,818,177	333,066,347	519,705,501	129,751,830	(56,887,324)
	Tier 2 - Payden & Rygel	53,728,565				
	Tier 2 - MetLife	53,381,862				
TNE Requirement		107,110,427	102,425,013	102,425,013	4,685,415	4,685,415
	Consolidated:	**569,928,604**	**435,491,360**	**622,130,514**	**134,437,245**	**(52,201,909)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
February 28, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	20,852,237	100,553,370
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	577,105	4,742,391
Changes in assets and liabilities:		
Prepaid expenses and other	(3,561,502)	(2,424,334)
Catastrophic reserves		
Capitation receivable	(3,016,554)	(7,616,475)
Medical claims liability	51,522,853	393,066,834
Deferred revenue	(13,095,828)	(449,932)
Payable to health networks	(8,833,604)	(105,009,109)
Accounts payable	(514,675)	(43,256,584)
Accrued payroll	615,510	(2,767,541)
Other accrued liabilities	71,910	50,619
Net cash provided by/(used in) operating activities	44,617,452	336,889,240
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	(223,749,694)	(710,104,312)
Change in Property and Equipment	(299,588)	(5,008,349)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	3,853,512	563,036
Change in Homeless Health Reserve	536,739	40,636,739
Net cash provided by/(used in) investing activities	(219,659,031)	(673,912,836)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(175,041,579)	(337,023,596)
CASH AND CASH EQUIVALENTS, beginning of period	$661,507,328	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**486,465,749**	**486,465,749**

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BALANCE SHEET – FEBRUARY MONTH:

ASSETS of $3.4 billion increased $50.6 million from January or 1.5%

- Operating Cash and Short-term Investments net increase of $48.7 million due to timing of the cash payment for the quarterly Managed Care Organization (MCO) tax in the prior month
- Capitation Receivables increased $2.1 million

LIABILITIES of $1.8 billion increased $29.8 million from January or 1.7%

- Claims Liabilities increased $51.5 million due to COVID-19 and Proposition 56 risk corridor estimates
- Offset by
  - Deferred Revenue decreased $13.1 million due to recognition of HHIP revenue
  - Capitation and Withholds decreased $8.8 million due to timing of capitation payments

NET ASSETS of $1.5 billion, increased $20.9 million from January or 1.4%

CalOptima Health - Consolidated
Net Assets Analysis
For the Eight Months Ended February 28, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 2/28/2023	**$1,520.0**			**100.0%**
Resources Assigned	Board Designated Reserve*	**569.9**			**37.5%**
	Capital Assets, net of depreciation	**67.1**			**4.4%**
Resources Allocated	Homeless Health Initiative**	$23.2	$59.9	$36.7	1.5%
	Housing and Homelessness Incentive Program***	40.1	40.1	0.0	2.6%
	Intergovernmental Transfers (IGT)	61.6	111.7	50.2	4.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning Measurement Year (MY) 2023	153.5	153.5	0.0	10.1%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	1.0%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.7%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	5.0	5.0	0.0	0.3%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	1.3	2.0	0.7	0.1%
	Digital Transformation and Workplace Modernization	94.2	100.0	5.8	6.2%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.6%
	Subtotal:	**$446.9**	**$566.2**	**$119.4**	**29.4%**
Resources Available for New Initiatives	Unallocated/Unassigned*	**$436.1**			**28.7%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 101 days of CalOptima Health's current operations
**See Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives (Page 30)
*** On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

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CalOptima Health
Key Financial Indicators
As of February 2023

Income Statement

Item Name	Month-to-Date (February 2023) Actual	Budget	Variance	%		FY 2023 Year-to-Date (February 2023) Actual	Budget	Variance	%	
Member Months	976,552	913,151	63,401	6.9%		7,562,378	7,305,918	256,460	3.5%	
*Operating Revenue **	320,752,951	329,850,106	(9,097,155)	(2.8%)		2,621,579,775	2,673,516,085	(51,936,310)	(1.9%)	
*Medical Expenses **	287,055,217	297,363,354	10,308,137	3.5%		2,424,662,289	2,500,925,224	76,262,935	3.0%	
General and Administrative Expense	15,108,328	18,757,199	3,648,871	19.5%		119,454,202	142,318,218	22,864,016	16.1%	
Non-Operating Income/(Loss)	2,262,831	(1,487,087)	3,749,918	252.2%		23,090,086	(6,961,630)	30,051,716	431.7%	
Summary of Income & Expenses	20,852,237	12,242,466	8,609,771	70.3%		100,553,371	23,311,013	77,242,358	331.4%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	89.5%	90.2%	(0.7%)		92.5%	93.5%	(1.1%)	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	4.7%	5.7%	1.0%		4.6%	5.3%	0.8%	

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@2/28/2023	2,281,228,481	2,060,037,620	221,190,861	10.7%

Unallocated/Unassigned Reserve Balance	Current Month @ February 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	436,096,975	448,294,548	(12,197,573)	(2.7%)
*Days Cash On Hand***	101			

*$135M of Directed Payments (DP) are included in YTD revenue and $133M of DP are included in YTD expenses.
**Total of Board Designated reserve and unallocated reserve amount can support approximatley 101 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Eight Months Ending February 28, 2023

	FY 2022-23 Month-to-Date				FY 2022-23 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**260,567**	**925,000**	**664,433**	**71.8%**	**3,464,781**	**35,946,000**	**32,481,219**	**90.4%**
Operating Expenses:								
Salaries, Wages & Benefits	374,331	487,935	113,604	23.3%	1,310,964	3,199,468	1,888,504	59.0%
Professional Fees	(27,000)	186,041	213,041	114.5%	63,088	1,488,328	1,425,241	95.8%
Purchased Services	-	13,333	13,333	100.0%	-	106,664	106,664	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	550,515	274,365	(276,150)	(100.7%)	999,767	2,194,920	1,195,153	54.5%
Total Operating Expenses	**897,846**	**961,674**	**63,828**	**6.6%**	**2,373,818**	**6,989,380**	**4,615,562**	**66.0%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	5,838,599	47,323,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**94,161,401**	**52,676,887**

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of February 28, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Homeless Coordination at Hospitals	10,000,000	9,197,577	802,423
Recuperative Care	6,194,190	6,194,190	-
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,913	3,170,400	6,718,514
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Days, HCAP and FQHC Administrative Support	963,261	620,719	342,542
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
FQHC (Community Health Center) Expansion	21,902	21,902	-
Medical Respite	250,000	250,000	-
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$100,000,000**	**$36,691,170**	**$63,308,830**
Transfer of funds to HHIP	(40,100,000)		(40,100,000)
Program Total	**$59,900,000**	**$36,691,170**	**$23,208,830**

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CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP)
As of February 28, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	5,000,000	-	5,000,000
Infrastructure Projects	10,500,000	-	10,500,000
Capital Projects	21,000,000	-	21,000,000
Subtotal of Approved Initiatives	**$ 40,100,000**	**$ -**	**$ 40,100,000**
Program Commitment Balance, available for new initiatives	-	-	-
Program Total	**$ 40,100,000**	**$ -**	**$ 40,100,000**

Note: On March 2, 2023, the Board of Director's approved allocation of $12.6M received from DHCS for the Housing and Homelessness Incentive Program to Capital Projects. This additioanal funding will be included in the March report.

CalOptima Health
Budget Allocation Changes
Reporting Changes for February 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	No budget reallocations for July					2022-23
August	Medi-Cal	Health Reward Incentive Fulfillment	Health Reward Incentive Fulfillment	$75,000	To reallocate funds from Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards	2022-23
September	No budget reallocations for September					2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services	2022-23
November	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$75,000	To reallocate funds from OC Customer Service – Member Communication to OC Cultural & Linguistic Services – Purchased Services to provide additional funding for translation of documents due to OCC/OC transition	2022-23
November	Medi-Cal	Human Resources - Cert/Cont. Education	Human Resources - Training & Seminars	$10,000	To reallocate funds from HR Onsite Computer Classes to Training & Seminars, HR Staff Development (for the CPS Academy classes)	2022-23
November	Medi-Cal	Population Health Management - Professional Fees	Case management - Training & Seminars	$27,000	To reallocate funds from Population Health Management – Purchased Services to Case Management – Training & Seminars to provide funding for WPATH training	2022-23
December	Medi-Cal	Quality Improvements - Subscriptions	Quality Improvements - Purchased Services	$75,000	To reallocate funds from Subscriptions – CAQH Application Subscription – Credentialing Database to Purchased Services to provide funding for additional credentialing services with a new vendor	2022-23
December	Medi-Cal	Communications - Purchased Services	Communications - Public Activities	$10,000	To reallocate funds from Purchased Services to Public Activities to provide funding for additional Medi-Cal Campaigns Support	2022-23
December	Medi-Cal	Population Health Management - Purchased Services	Quality Improvements - Purchased Services	$24,950	To reallocate funds from Population Health Management – Purchased Services to Quality Improvement – Purchased Services to provide additional funding for CVO credentialing services	2022-23
December	PACE	Capital: Interior Light Improvement	Capital: Additional Furniture, Fixtures and Equipment	$35,000	To reallocate funds from Interior Light Improvement to Additional Furniture Fixtures	2022-23
January	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
January	OCC	Sales & Marketing - Printing & Postage	Cultural & Linguistic Services - Purchased Services	$18,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OCC	Customer Service - Postage	Cultural & Linguistic Services - Purchased Services	$40,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OC	Sales & Marketing - Purchased Services General	Cultural & Linguistic Services - Purchased Services	$50,000	To reallocate funds from Sales & Marketing - Purchased Services to Cultural & Linguistic - Purchased Services for translations/interpreter services.	2022-23
January	Medi-Cal	Medical Management - Food Services	Medical Management - Professional Dues	$12,000	To reallocate funds from Medical Management Food Services to Medical Management Professional Dues to pay for Orange County Medical Association dues for the Medical Directors.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Office Suite Renovation & Improvements	$150,000	To reallocate funds from Facilities Building Security Projects to Facilities Office Suite Renovation for Improvements for 8th Floor HR renovation, 9th Floor Office renovation, 9th Floor hallway renovation and Directory signage.	2022-23
February	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Electric Car Charging Station	$30,000	To reallocate funds from Facilities Building Security Projects to Facilities Electric Car Charging Station.	2022-23
February	Medi-Cal	Renaming Capital : Touchless Faucet	Capital - 9th Floor Improvement	$183,000	To re-name and re-purpose to meet new fire code requirements for fire exiting on the 9th floor.	2022-23
February	OC	Sales & Marketing - Purchased Services General	Financial Analysis - Professional Fees	$30,000	To reallocate funds from Sales & Marketing Purchased Services to Financial Analysis Professional Fees for OneCare VBID Model.	2022-23
February	PACE	PACE Center Support - Repair & Maintenance	PACE Administrative - Professional Fees	$50,000	To reallocate funds from PACE Center Support Repair & Maintenance to PACE Administrative Professional Fees for anticipated PACE audit.	2022-23

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
April 6, 2023

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health'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/OneCare Connect/PACE

- 2023 DHCS PACE Audit *(applicable to PACE)*:

  - On February 22, 2023, CalOptima Health was formally engaged by the Department of Health Care Services (DHCS) for the PACE Program Audit. (The Centers for Medicare and Medicaid Services (CMS) will not participate in the audit.)
    - The following areas are included in the scope of the audit: Grievance documentation procedures, Clinical Appropriateness and Care Planning, Transportation, Personnel Records, Subcontractor Agreements, Serious Incident Reports, Onsite Review of the facility, Emergency Preparedness, Meal preparation and kitchen procedures.
  - On February 28, 2023, CalOptima Health attended a call with DHCS to review the audit process and deliverables.
    - DHCS will conduct the onsite review from April 11, 2023, through April 13, 2023.
    - The final deadline to submit the deliverables to DHCS is March 24, 2023.
    - On 3/13/23, CalOptima Health submitted the deliverables to DHCS and is awaiting sample selections from DHCS.

- CY21 Medicare Part D Improper Payment Measure (IPM) *(applicable to OneCare (OC) and OneCare Connect (OCC)*:

  - January 13, 2023-- CMS notified CalOptima Health of its selection for CY21 Part D IPM
    - CMS conducts the Part D IPM activity to validate the accuracy of Prescription Drug Encounter (PDE) data submitted by Medicare Part D Sponsors to CMS for payments.
  - February 10, 2023 -- documentation submitted to CMS
    - CMS issued the audit element check results noting a "pass" for all three (3) samples.

- 2021 Centers for Medicare & Medicaid Services (CMS) Program Audit/Independent Validation Audit (IVA)/2023 Revalidation Audit *(applicable to OC and OCC)*:

- On 1/10/23, CalOptima Health received the Revalidation Notification Letter from CMS stating that CalOptima Health is required to submit a CAP for the remaining two conditions found from the validation audit:
  - Formulary Administration (FA) #2.06
  - Special Needs Plan – Model of Care (SNP-MOC) #5.41
- On 1/12/23, CalOptima Health submitted the CAP for FA #2.06 and on 1/18/23, the CAP was submitted for SNP-MOC #5.41.
- On 2/27/23, CalOptima attended a call with CMS to discuss the revised FA CAP. CMS requested an additional revised FA CAP including a timeframe for CMS to conduct the validation. The requested documents were submitted to CMS on 3/3/23.
- On 3/15/23, CMS approved the SNP MOC CAP and requested for CalOptima to begin revalidation of this condition. CalOptima is currently awaiting feedback from CMS on the FA CAP.
- CalOptima has 180 days or until 7/9 to complete the revalidation activity and submit the final revalidation audit report to CMS.

- 2023 Medicare Part C and Data Part D Data Validation Audit (MDVA) *(applicable to OC)*:

  - CMS requires Sponsors to participate in a yearly independent review to validate data reported to CMS per the Medicare Part C and Part D Reporting Requirements.
  - The audit includes the following Medicare Parts C and D measures:
    - Part C and D Grievances
    - Organization Determinations and Reconsiderations
    - Coverage Determinations and Redeterminations
    - Medication Therapy Management (MTM) Program
    - Special Needs Plan (SNP) Care Management
    - Improving Drug Utilization Review (IDUR) Controls
  - The audit is expected to be conducted from March to June 2023.

- Analysis of Nuedexta PDEs without Medically Accepted Indication *(applicable to OC)*:

  - On July 13, 2021, CMS informed CalOptima Health that its OC program was selected to participate in the Analysis of Prescription Drug Event Records for Nuedexta for Beneficiaries without a Medically Accepted Indication (MAI).
    - CMS in collaboration with the Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC), conducted a review of Medicare Part D payments for Nuedexta without a documented MAI under the Medicare Part A, Part B, or Part C programs and has determined that CalOptima Health submitted potentially inappropriate payments for prescription drug event (PDE) records. The Nuedexta national audit covers PDE records from January 1, 2019, through December 31, 2020.
  - On July 30, 2021, CalOptima Health submitted the requested documentation.
  - On January 10, 2023, the final results from the National Audit of Medicare Part D payments for Nuedexta were provided from CMS stating that two (2) PDE records are to be deleted by March 1, 2023.
  - On January 26, 2023, CalOptima Health received confirmation that the two (2) PDE deletions were accepted by CMS with no further action needed.

2. Medi-Cal

- 2024 Managed Care Plan (MCP) Operational Readiness Contract:

  Update:

  As of March 2, 2023, CalOptima Health has **submitted a total of 124 deliverables** for 2024 MCP operational readiness. To date, CalOptima Health has received **approval for 109** items. The remaining deliverables are awaiting response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.

  On-track for all remaining deliverables.

  Background – FYI Only

  Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by the January 1, 2024, contract effective date.

- 2023 DHCS Medical Audit:

  Update:

  Annual (routine) Audit:
  - Scope included:
    - Utilization management
    - Case management and coordination of care
    - Availability and accessibility
    - Member rights
    - Quality management
    - Administrative and organizational capacity
  - Staff interviews concluded; audit remains open
    - Interviews were conducted February 27 through March 3, 2023
    - DHCS hosted a soft exit on March 2, 2023
    - DHCS noted that the staff interviews were concluded
    - Document reviews were to continue
    - No preliminary findings will be shared with the Plan
    - All findings will be noted in the draft findings report which they hope to provide within three months (~June 2023)
    - DHCS thanked CalOptima Health for its participation and timely response to audit requests

  Next Steps:
  - CalOptima Health will receive the draft findings report 1-2 days prior to the (to be scheduled) Exit Conference.

- CalOptima Health will have 15 calendar days (from the day of the Exit Conference) to review the findings and submit any rebuttals.
- Once the findings report is finalized by DHCS, a formal request for corrective action will be communicated.

Although DHCS did not identify observations, RAC will proactively begin outreach and engagement to ensure mitigation and resolution to areas of opportunity, identified during the audit prep and interviews, are remediated.

Focused Audit:
- Scope included:
  - Transportation
  - Behavioral Health
- Staff interviews were conducted February 27 through March 8, 2023
- No soft exit
- Once DHCS concludes its review of all managed care plans (MCPs), a report is anticipated to be released by Q2 2024. More information to follow as DHCS finalizes and communicates next steps.

Background – FYI Only

- Key points/dates:
  - Lookback-period: 2/1/22 - 1/31/23
  - Line of Business: Medi-Cal (including SPD and Non-SPD population), OneCare Connect
  - Delegate Impact: Yes, Monarch was selected to participate
  - Audit Interviews: 2/27/23 - 3/10/23, will occur virtually
  - Entrance Conference: 2/27/23 at 9:00am, will occur virtually
  - Provider Office Impact: Yes. The audit will also involve facility site visits and medical record review; this means potential impact to Provider offices.

- 2021 DHCS Medical Audit:

Update: On December 22, 2022, CalOptima Health submitted its formal corrective action plan (CAP) to DHCS. CalOptima Health must provide **monthly updates** on findings with future milestones. These monthly updates will continue until all milestones have been reached and/or DHCS determines the CAP is closed. CalOptima Health's February update was provided to DHCS timely, and we remain on-track for a timely March update.

- 2022 Managed Care Entity (MCE) Program Integrity (PI) Review:

Update: No updates.

Background – FYI Only
- April 13, 2022, the DHCS notified CalOptima Health that it had been selected to provide feedback to CMS in respect to CalOptima Health's internal PI efforts that are in place to ensure adequate oversight as well as to deter and address FWA.
- Review period was the preceding 3 Federal Fiscal Year (FFYs).

- Focused on CalOptima Health's Medi-Cal program. DHCS requested that CalOptima Health respond to a series of questions within the CMS Template and submit responses and supporting documentation to DHCS, which DHCS would then submit to CMS.
- May 4, 2022, CalOptima Health provided its timely response to DHCS.
- On 10/27/22, CalOptima Health met virtually with CMS & DHCS to discuss the internal PI efforts in place to ensure adequate oversight, as well as to deter and address fraud, waste, and abuse.
  - As requested by the auditors, CalOptima Health submitted a number of supporting documents and narrative responses by 11/10/22.

B. Regulatory Notices of Non-Compliance

- DHCS Quality Sanction

  - DHCS issued a quality sanction notice to CalOptima Health in the amount of $25,000 for falling below the Minimum Performance Level (MPL) for two measurement year (MY) 2021 Medi-Cal Managed Care Accountability Set (MCAS) measures.
  - The final notice was issued to CalOptima Health on February 15, 2023, and CalOptima Health had 15 business days (3/9/23) to request a hearing to appeal the sanction.
  - CalOptima Health submitted a request on March 3, 2023, for a hearing to appeal the sanction.

- CMS Ad Hoc CAP Request – Part C Star Rating

  - On February 22, 2023, CMS issued a Compliance notice with a CAP request to CalOptima Health's OneCare (H5433) Plan, for receiving a 2.5 Part C Star Rating.
    - This is considered an ad hoc CAP request, which is 6 points on CalOptima Health's past performance score.
    - CalOptima Health is now at 12 points on the past performance score. At 13 points or more, CMS may deny an application for new contracts, PBPs, or service area expansions.
    - This should not impact CalOptima Health's 2024 filing and most of the points will drop of by the time 2025 filings are due, unless additional compliance letters are received from CMS.
    - A star rating below 3 stars for 3 years in a row may lead to contract termination or other compliance action, which could include denial of an application for an expansion of service area or PBPs.
  - CMS is requesting CalOptima Health develop and implement a CAP designed to ensure that it will achieve at least an "average" star rating (3 stars).
  - Quality Improvement has developed a CAP as of March 13, 2023.

C. Updates on Internal and Health Network Monitoring and Audits

- **Update:** No updates.

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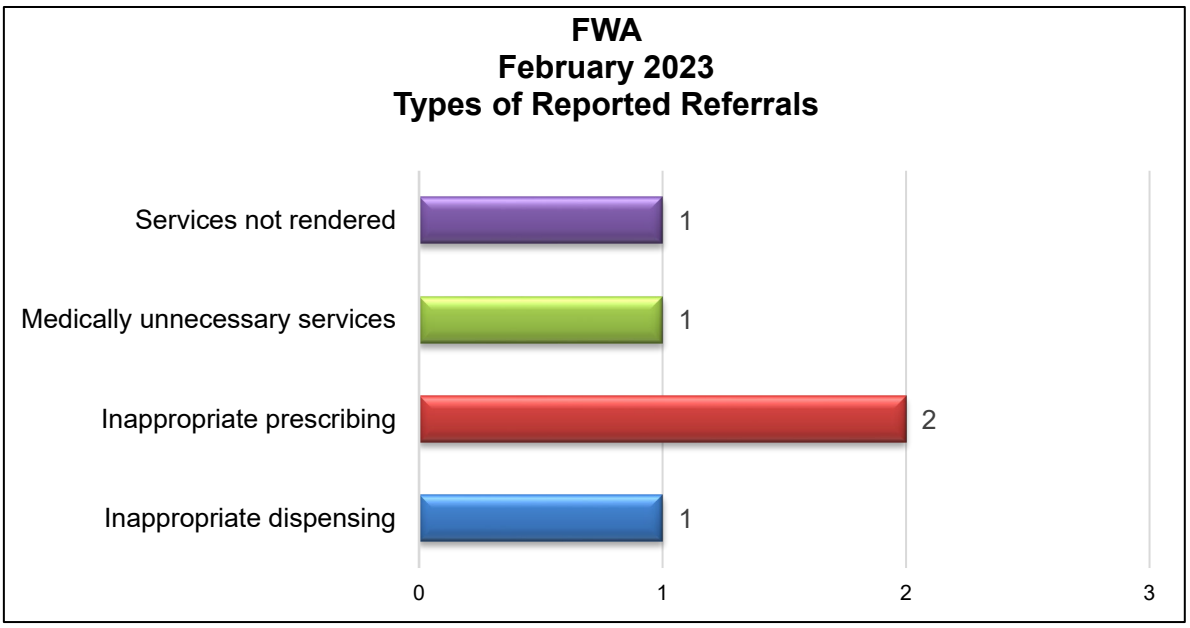
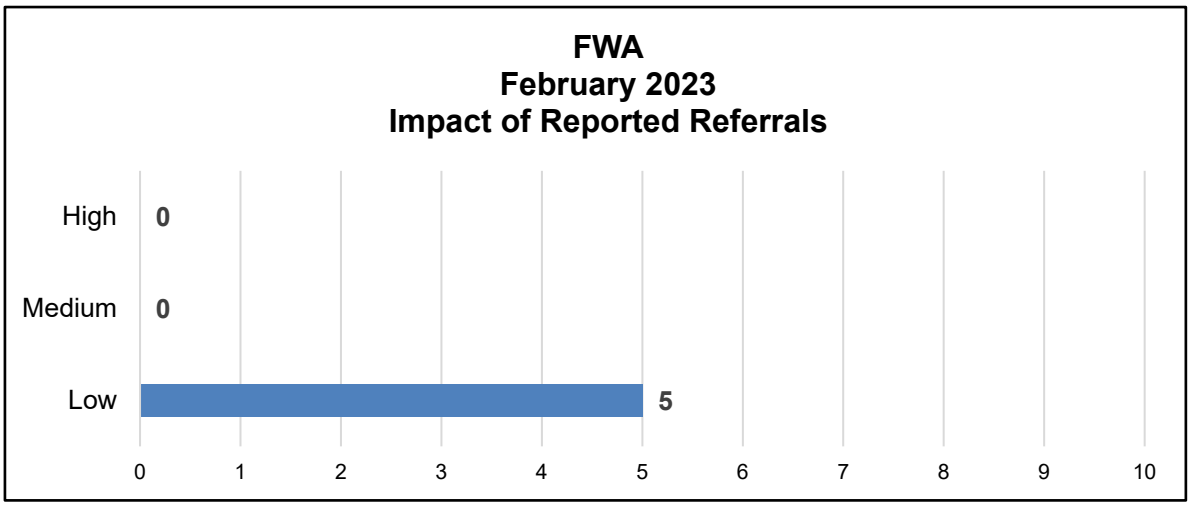
D. Fraud, Waste & Abuse (FWA) Investigations (February 2023)

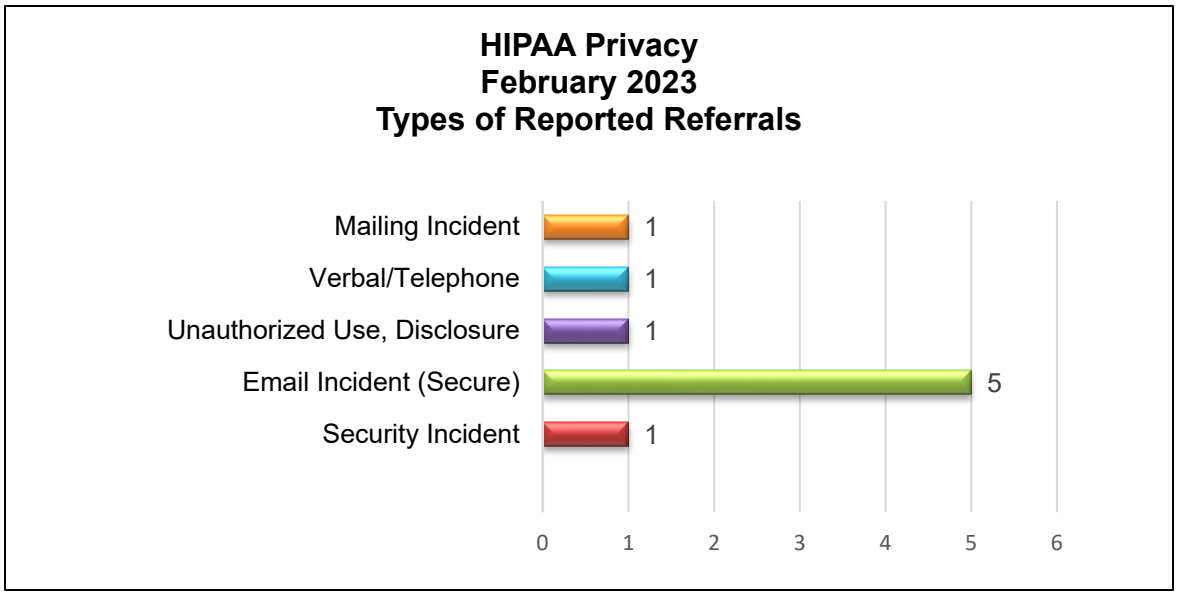


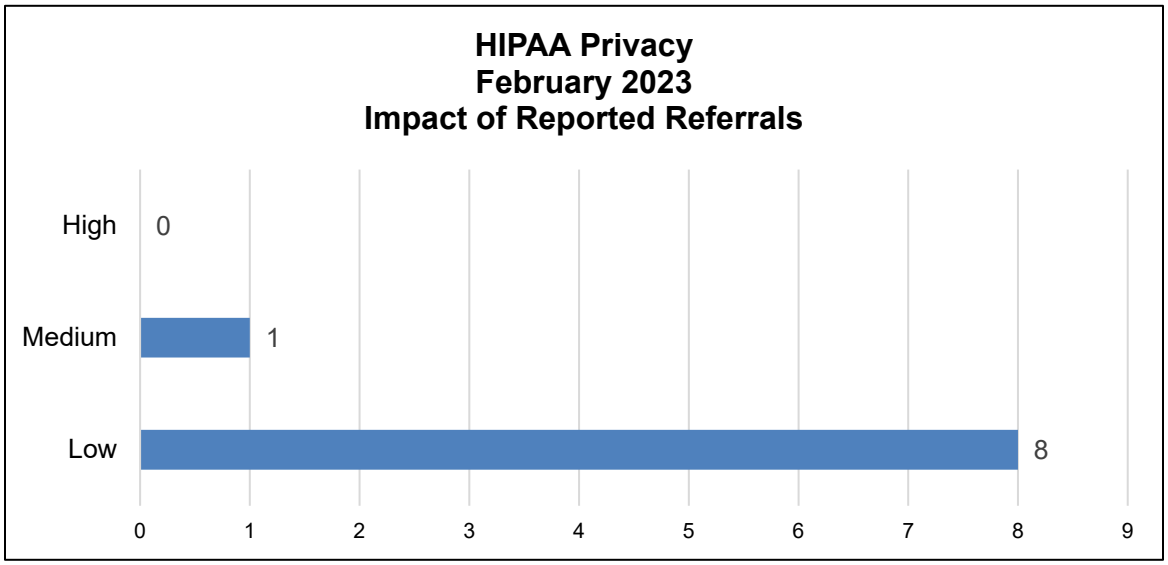


Total Number of New Cases Referred to DHCS (State)	5
Total Number of New Cases Referred to DHCS and CMS*	1
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**5**

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

E. Privacy Update: (February 2023)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	9
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

March 10, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: March Board of Directors Report

FISCAL YEAR 2024 (FY24) BUDGET AND APPROPRIATIONS

President Biden released his annual budget request to Congress on March 9th. The President's budget is the official starting point for the annual appropriations process, but ultimately Congress holds the power of the purse and is responsible for all spending decisions. Once the President's Budget is released, the House and Senate Appropriations Committees will hold hearings with Department Secretaries to discuss their Departmental requests for funding. The full President's Budget is available here.

The House and Senate Appropriations Committees have released their guidance for FY24 "earmarks", called Community Project Funding (CPF) in the House and Congressionally Directed Spending (CDS) in the Senate. The House CPF guidance is available here, and the Senate guidance is available here. The House made significant changes to select accounts. For instance, total earmark spending for FY24 will not exceed 0.5% of total discretionary spending, reducing the overall earmark cap by 50% compared to FY23. Additionally, all new projects must have a "federal nexus". Memorials, museums, and commemoration projects are no longer eligible, and the Health and Human Services (HHS) and Financial Services accounts are not eligible for earmarks at all.

PUBLIC HEALTH EMERGENCY (PHE) WILL END ON MAY 11TH

On February 9th, HHS Secretary Xavier Becerra sent a letter to US Governors on renewing the PHE. Rather than the promised 60 days' notice, the Secretary provided 90 days' notice before the COVID-19 PHE ends to give governors and their communities ample time to transition. The full letter is available here. A factsheet on the PHE Transition roadmap is available here.

CMS has released the list of states' anticipated timelines to begin renewing eligible Medicaid enrollments and terminating others at the conclusion of the PHE. Under the Families First

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Coronavirus Response Act, states must maintain nearly all their Medicaid enrollees during the PHE to receive a temporary 6.2 percentage point FMAP (Medicaid payment) increase and will have up to 14 months to return to normal eligibility and enrollment operations after the emergency. Following that, the Continuing Appropriations Act of 2023 delinked the continuous enrollment requirement from the PHE and placed the end of the mandatory enrollment program on March 31, with the FMAP increase phasing out beginning April 1 and ending on Dec. 31, 2023. The full list of timelines is available here.

As the PHE winds down and the continuous enrollment provision ends, as many as 6.7 million children could lose their health coverage – many who are still eligible – as the states begin to review and drop ineligible beneficiaries. A new study by the Georgetown Center for Children and Families states that the "uninsured rate for children could easily more than double if states have inadequate staffing levels and overwhelmed call centers and do not take the time and care needed to properly conduct eligibility checks after the federal protections lift." Click here for the report.

SENATE HEARING ON HEALTHCARE WORKFORCE SHORTAGE

On February 16th, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing titled "*Examining Health Care Workforce Shortages: Where Do We Go From Here?"* Increasing training slots, expanding visa allowances, and recruiting minority students were some of the suggestions of how to boost the health care workforce. Concerns over rising violence against health care workers were brought up as a disincentive, with the need to increase protections. Another topic was physician burnout which has been the subject of many surveys recently, with the recommendation that hospitals should initiate wellness programs for their staff. To watch the hearing, click here, and for an overview of the hearing, click here.

MEDICARE ADVANTAGE (MA)

There is an escalating fight taking place between MA plans and HHS over the latter's proposed payment increase for FY24. MA plans are lambasting the proposed increase, arguing that it is really a payment cut that will hurt beneficiaries. HHS and CMS leaders say MA plans are not telling the truth. MA plans are spending millions of dollars on advertising to make their point, going toe-to-toe with the Biden Administration to fight proposed payment changes next year. Starting with a Super Bowl advertisement urging seniors to call the White House and Congress and tell them not to cut MA, the commercials are now running on all the major news channels. They have also set up a website dontcutmedicareadvantage.com that describes the harm that the cuts could have on the health care of seniors and those with disabilities. Click here for more on the campaign from the Wall Street Journal.

COMMUNITY HEALTH CENTERS

Community Health Centers are due for federal reauthorization this year, amounting to $4 billion or more in funding. In a hearing last week before the Senate HELP Committee, witnesses stated that centers need $6 billion in funding for the upcoming reauthorization to stave off what they are calling the "primary care cliff." This request comes as a number of programs that will require funding are up for reauthorization this year, with limited funding available and a Republican House concentrated on cutting the budget. To watch the hearing, click here.

TELEHEALTH

Medicare telehealth codes had previously been extended by CMS for 151-days post-PHE to comport with the telehealth flexibilities that Congress had extended in the Consolidated Appropriations Act, 2022. This extension fixes the gap in some services that could have occurred post-PHE. In addition, the CY24 Physician Fee Schedule proposed rule is now expected to include these telehealth services that were further extended by the Consolidated Appropriations Act, 2023, through CY24. The full list of telehealth codes extended through CY2024 is available here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

March 28, 2023

CalOptima Health
LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

With the bill introduction deadline behind us, the Legislature now turns to policy committee hearings for the first house. The Legislature will have until April 28 for all fiscal bills to be heard in policy committee. Until this date (aside from Spring Recess from March 30 – April 10), the Legislature will be busy conducting hearings for bills introduced this year. This includes many of the "spot" or "intent" bills that have since been amended with substantive language that will allow them to move forward in the legislative process.

Non-fiscal bills will have until May 5 to be heard in policy committee.

This month, the Governor announced that he is working with Senator Susan Eggman to propose a 2024 ballot initiative on mental health, homelessness and substance abuse that would establish a general obligation bond to fund new treatment beds in various settings, provide more funding for housing homeless veterans and update the Mental Health Services Act (MHSA) to allow funding to be used for housing needs, among other changes.

Legislation of Interest

AB 271 (Quirk-Silva) - Homeless Death Review Committee. This bill would allow counties to establish a homeless death review committee to gather information to identify the root causes of death of homeless individuals as well as determine strategies to improve the coordination of services for this population.

AB 271 passed out of the Assembly in early March and is now pending referral to a policy committee in the Senate.

CalOptima Health supports this bill.

SB 598 (Skinner) - Prior Authorization. This bill would prohibit insurance plans from requiring contracted physicians and other health professionals to get prior authorization for any covered services if the plan approved or would have approved no less than 90% of prior authorization requests in the last one-year contract period. We are watching this bill closely.

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www.egrslobby.com

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The bill is set for a hearing in the Senate Health Committee on April 12.

Public Meeting Bills – Since the onset of the COVID-19 pandemic, teleconferencing flexibilities have become a subject of interest in California's Legislature, with local government groups sponsoring various bills on the topic since 2021. This session is no exception, and multiple bills on the topic have been introduced:

AB 557 (Hart) - AB 361 Sunset Extension. This bill would remove the sunset established in AB 361 (R. Rivas) as well as increase the time period when the Board must renew the findings of an emergency or need for social distancing from 30 days to 45 days.

AB 817 (Pacheco) – Open Meeting Flexibility for Subsidiary Bodies. This bill allows subsidiary bodies to use teleconferencing without regard to a state of emergency if they meet certain requirements. Subsidiary bodies are bodies that serve in an advisory capacity and do not take final action on specified items.

AB 1379 (Papan) - Teleconference Flexibilities. AB 1379 expands various flexibilities for local agencies under the Brown Act including, but not limited to, relaxing requirements for posting teleconference locations, relaxing certain quorum requirements, removing the existing January 1, 2026 sunset date of flexibilities in current law, and removing restrictions that prohibit members from participating remotely for more than two meetings a year, among other changes. The bill also requires that a legislative body have at least two meetings a year where members are in person at a single designated location.

SB 411 (Portantino) - Teleconferencing for Appointed Bodies. This bill would allow local legislative bodies with appointed members to use teleconferencing indefinitely regardless of the presence of an emergency. The author intends this bill to apply to neighborhood councils. The bill is an urgency bill and therefore requires a 2/3 vote.

SB 537 (Becker) - Teleconference Flexibilities. This bill was recently amended with substantive language that allows multijurisdictional, cross county legislative bodies to use teleconferencing indefinitely and without regard to a state of emergency and adds certain requirements, like requiring a legislative body to provide a record of attendance on its website within 7 days of the meeting. The bill also adds to the list of circumstances where a member is permitted to participate remotely. The bill is an urgency bill and therefore requires a 2/3 vote.

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2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or substance use disorder crisis.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment**: Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities.	**02/14/2023** Introduced	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions**: Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary or involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment.	**02/16/2023** Introduced	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2025, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or substance use disorder treatment.	**03/22/2023** Passed Senate Health Committee; referred to Senate Judiciary Committee	CalOptima Health: Watch

California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change Remediation:** Would add "climate change remediation" as a Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather or other climate events, including air conditioners, heaters, air filters and generators.	**02/09/2023** Introduced	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, recreational sports, and mental wellness memberships as a Community Support option.	**02/16/2023** Introduced	CalOptima Health: Watch
Covered Benefits			
AB 47 Boerner Horvath	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy.	**12/05/2022** Introduced	CalOptima Health: Watch CAHP: Oppose
AB 85 Weber	**Social Determinants of Health (SDOH) Screenings:** Beginning January 1, 2024, would add SDOH screenings as a covered Medi-Cal benefit. Would also require health plans to provide primary care providers with adequate access to community health workers.	**12/16/2022** Introduced	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit, subject to utilization controls based on clinical practice guidelines. Would also authorize DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS.	**03/21/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Would add pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications.	**02/06/2023** Introduced	CalOptima Health: Watch
AB 608 Schiavo	**Perinatal Services**: Would require DHCS to cover additional perinatal assessments, individualized care plans, visits and units of services during the one-year postpartum Medi-Cal eligibility period that are at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would be required to collaborate with the California Department of Public Health and stakeholders to determine the specific levels of additional coverage.	**02/09/2023** Introduced	CalOptima Health: Watch
AB 620 Connolly	**Digestive and Metabolic Disorders:** Beginning January 1, 2024, would require health plans to expand coverage for the testing and treatment of phenylketonuria (PKU) to include other digestive and inherited metabolic disorders. Coverage would include the formulas and special food products that are part of a prescribed diet.	**02/09/2023** Introduced	CalOptima Health: Watch CAHP: Oppose

AB 719 Boerner Horvath	**Public Transit**: Would require Medi-Cal managed care plans to contract with public transit operators for nonmedical and nonemergency medical transportation services. Would require reimbursement to be based on the Medi-Cal fee-for-service rates for those services.	**02/13/2023** Introduced	CalOptima Health: Watch LHPC: Oppose Unless Amended CAHP: Oppose
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Would extend Medi-Cal eligibility for palliative care and hospice services, including concurrently, after 21 years of age for individuals who were previously determined eligible prior to 21 years of age.	**02/14/2023** Introduced	CalOptima Health: Watch
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would require a health plan to provide coverage for treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) prescribed or ordered by a provider.	**02/14/2023** Introduced	CalOptima Health: Watch CAHP: Oppose
AB 1085 Maienschein	**Housing Support Services**: Would require DHCS to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services	**03/21/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CalPACE: Support
AB 1644 Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals.	**02/17/2023** Introduced	CalOptima Health: Watch
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would require health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer.	**01/30/2023** Introduced	CalOptima Health: Watch CAHP: Oppose
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would add SMBP devices and related services as covered Medi-Cal benefits for the treatment of high blood pressure.	**02/16/2023** Introduced	CalOptima Health: Watch CalPACE: Support
Medi-Cal Eligibility and Enrollment			
AB 564 Villapadua	**Medi-Cal Applications:** Would require DHCS to allow Medi-Cal applicants and providers to submit electronic signatures for all enrollment forms, including, but not limited to, claims and remit forms.	**02/08/2023** Introduced	CalOptima Health: Watch

AB 1481 Boerner Horvath	**Medi-Cal Presumptive Eligibility for Pregnancy**: Would expand presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). Would make a presumptively eligible pregnant person eligible for all covered Medi-Cal benefits, except for inpatient services and institutional long-term care. If an application for full-scope Medi-Cal benefits is submitted within 60 days of a PE4PP determination, PE4PP coverage would be effective until the Medi-Cal application is approved or denied.	**02/17/2023** Introduced	CalOptima Health: Watch
SB 299 Eggman	**Medi-Cal Redeterminations:** Would remove the current requirement for a county to send a notice of action terminating Medi-Cal eligibility if the prepopulated redetermination form is returned as undeliverable and the purpose for the redetermination is loss of contact with the beneficiary.	**03/22/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
Medi-Cal Operations and Administration			
AB 557 Hart	**Brown Act Flexibilities:** Would permanently extend current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Would also extend the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days.	**02/08/2023** Introduced	CalOptima Health: Watch
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would prohibit health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy.	**02/14/2023** Introduced	CalOptima Health: Watch LHPC: Oppose Unless Amended CAHP: Oppose
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, when prescribed according to generally accepted national professional guidelines.	**02/16/2023** Introduced	CalOptima Health: Watch CAHP: Oppose
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program.	**02/17/2023** Introduced	CalOptima Health: Watch LHPC: Oppose
SB 324 Limón	**Endometriosis Prior Authorization:** Beginning January 1, 2024, would prohibit health plans from requiring prior authorization or other utilization review for laparoscopic surgery for endometriosis.	**02/06/2023** Introduced	CalOptima Health: Watch LHPC: Oppose Unless Amended CAHP: Oppose
SB 411 Portantino	**Brown Act Flexibilities:** Would authorize an appointed board, commission or advisory body of a local agency to use alternate teleconferencing provisions, similar to current provisions in effect during the COVID-19 state of emergency, indefinitely and without regard to a state of emergency.	**02/09/2023** Introduced	CalOptima Health: Watch

SB 598 Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2025, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period.	**02/15/2023** Introduced	CalOptima Health: Watch LHPC: Oppose Unless Amended CAHP: Oppose
Older Adult Services			
AB 1022 Mathis	**Program of All-Inclusive Care for the Elderly (PACE) Reforms**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments.	**02/15/2023** Introduced	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries.	**02/16/2023** Introduced	CalOptima Health: Watch
SB 311 Eggman	**Medicare Part A Buy-In:** No later than January 1, 2024, would require DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with the Centers for Medicare and Medicaid Services (CMS).	**03/22/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch LHPC: Support CalPACE: Support
Providers			
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 904 Calderon	**Doulas**: Beginning January 1, 2025, would require a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas.	**02/14/2023** Introduced	CalOptima Health: Watch
Rates & Financing			
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss.	**02/07/2023** Introduced	CalOptima Health: Watch

AB 576 Weber	**Abortion Reimbursement**: Would require DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion.	**02/08/2023** Introduced	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program.	**02/17/2023** Introduced	CalOptima Health: Watch
SB 282 Eggman	**Federally Qualified Health Center (FQHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit. In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit."	**02/01/2023** Introduced	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services.	**02/07/2023** Introduced	CalOptima Health: Watch LHPC: Support
Social Determinants of Health			
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library.	**01/19/2023** Introduced	CalOptima Health: Watch
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Would authorize counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population.	**03/06/2023** Passed Assembly floor; referred to Senate	**03/02/2023** CalOptima Health: Support

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: March 28, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	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 in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health 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 serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
April 6, 2023
CalOptima Health Community Outreach Summary — March and April 2023

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups as well as supports our community partners' public activities.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

We continue to participate in public activities virtually in most instances, with limited in-person attendance. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

Community Outreach Highlight

During the COVID-19 public health emergency, Medi-Cal members kept their coverage regardless of changes in circumstances. However, starting April 1, the County of Orange Social Services Agency (SSA) will begin checking if members still qualify for coverage via a process known as Medi-Cal redetermination or Medi-Cal renewal. Current contact information is needed so members can receive notices from SSA.

To increase awareness of the upcoming changes for our members and ensure the continuity of their Medi-Cal benefits, in March, CalOptima Health partnered with SSA and Covered California to host two webinars on the Medi-Cal redetermination process. Health care partners and community stakeholders received updates regarding the annual renewal, including the timeline, how CalOptima Health members can prepare to report changes in contact information or circumstances, and communications strategy and resources for the community. Three sessions for members are scheduled for May 2 (English), May 3 (Spanish) and May 4 (Vietnamese).

Summary of Public Activities

As of March 20, CalOptima Health plans to participate in, organize or convene 80 public activities in March and April. In March, there will be 49 public activities, including 21 virtual community/collaborative meetings, 12 community-based presentations, 15 community events and one Health Network Forum. In April, there will be 31 public activities, including 17 virtual community/collaborative meetings, three community-based presentations, nine community events, one Health Network Forum and one Cafecito meeting. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided three endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Use of CalOptima Health's name and logo for Alzheimer's Orange County to promote Dementia Care Awareness and cognitive health assessments.

2. Letter of Support to Mind OC's application for Be Well Orange County's Accountable Community for Health to continue advancing special initiatives.

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3. Letter of Support for Vietnamese American Cancer Foundation's funding application to establish a new Accountable Community for Health to support health equity for Asian American and Native Hawaiian/Pacific Islander residents in Orange County.

   For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

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Community events hosted by CalOptima Health and community partners in March and April 2023:

March 2023			
3/1 11 a.m.–1 p.m.	**Vaccine Clinic hosted by Fullerton College** Fullerton College 321 E. Chapman Ave., Fullerton	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
3/2 8:30–9:30 a.m.	**CalOptima Health Medi-Cal Overview in English** California State University, Fullerton Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members/community
3/4 9 a.m.–1 p.m.	**School Readiness Fair hosted by Pretend City†** Pretend City Children's Museum 29 Hubble, Irvine	At least one staff member attended (in-person). Sponsorship fee: $1,000; included recognition as the stage sponsor; inclusion in collateral, marketing, media, social media and e-blasts; resource table at event; recognition on Pretend City's website; listing in event program; and 10 complimentary tickets to Pretend City for future use.	• Health/resource fair • Open to the public
3/5–3/7 9 a.m.–1:30 p.m.	**Health Summit hosted by Family Voices of California†** Virtual	Sponsorship fee: $5,000; included verbal recognition at the summit, logo on summit materials, inclusion on social media marketing, inclusion of one item in attendee packets and attendance for two representatives.	• Forum • Open to the public
3/7 2–3 p.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Lathrop Intermediate School 1111 S. Broadway., Santa Ana	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
3/9 5:45–6:45 p.m.	**CalOptima Health Medi-Cal Overview in English** Thomas House Family Shelter 12601 Morningside Ave., Garden Grove	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
3/10 10–11 a.m.	**CalOptima Health Medi-Cal Overview in English** Fullerton Elementary School District 1401 W. Valencia Dr., Fullerton	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
3/11 10–11 a.m.	**CalOptima Health Medi-Cal Overview in Spanish** La Habra High School 801 W. Highlander Ave., La Habra	At least one staff presented (in-person).	• Community-based organization presentation • Open to members/community
3/15 10 a.m.–Noon	**Equus Resource Fair hosted by Equus Workforce Solutions** Anaheim Downtown Community Center† 250 E. Center St., Anaheim	At least one staff member attended (in-person).	• Health/resource fair • Open to the public

* CalOptima Health-hosted
† Exhibitor/Attendee

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3/16 5:30–7:30 p.m.	**Cooking Up Change, Greater Orange County hosted by Kid Healthy and Northgate Market†** Northgate Gonzalez Market Headquarters 1201 N. Magnolia Ave., Anaheim	At least one staff attended (in-person). Sponsorship fee: $5,000; included company logo on all event materials at leader level, recognition in event handouts and signage at leader level throughout event, recognition in verbal announcements throughout event, company signage at check-in area, logo item or information in student event bags, opportunity to provide presentations at Padres en Acción program meetings at identified elementary schools (11–20 sites), six event tickets, and presentations at 2 student workshops.	• Health/resource fair • Open to the public
3/16 3–4 p.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Jamboree House 8004 Orangethorpe Ave., Buena Park	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
3/17 9 a.m.–Noon	**General Assembly Resource Fair hosted by Santa Ana Early Learning Initiative†** Delhi Center 505 E. Central Ave., Santa Ana	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
3/17 1–6 p.m.	**Spring of Hope hosted by Abrazar†** Delhi Center 505 E. Central Ave., Santa Ana	At least two staff members attended (in-person).	• Health/resource fair • Open to the public
3/17 10:30–11:30 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Friendly Center 6688 Beach Blvd., Buena Park	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
3/20 9–10 a.m.	**CalOptima Health Medi-Cal Presentation in Spanish** Whitten Community Center 900 S. Melrose St., Placentia	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
3/22 12:30–3 p.m.	**Health is Healing Health & Resource Fair hosted by College Community Services** Wellness Center Central 401 S. Tustin St., Orange	At least two staff members attended (in-person).	• Health/resource fair • Open to the public
3/22 11:30 a.m.–12:30 p.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Orange Coast College Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members/community

* CalOptima Health-hosted
† Exhibitor/Attendee

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3/23 1–4 p.m.	**Children Physicals and Family Resources hosted by Homeless Intervention Services OC†** Whitten Community Center 900 S. Melrose St., Placentia	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
3/25 9 a.m.–1 p.m.	**Community Health and Resource Fair hosted by the County of Orange Social Services Agency (SSA)†** Centennial Park 3000 W. Edinger Ave., Santa Ana	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
3/25 9a.m.–Noon	**Health Fair hosted by Jamboree Housing†** Richman Park 711 S. Highland Ave., Fullerton	At least one staff attended (in-person).	• Health/resource fair • Open to the public
3/29 1:30– 2:30 p.m.	**InfoSeries: Medi-Cal Redetermination*** Virtual	At least six staff members attended.	• Forum • Open to community stakeholders; registration required
3/29 4:45–5:45 p.m.	**CalOptima Health Medi-Cal Overview Presentation in Spanish** James Guinn Elementary School Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members/community
3/30 9–10 a.m.	**InfoSeries: Medi-Cal Redetermination*** Virtual	At least six staff members attended.	• Forum • Open to community stakeholders; registration required
3/30 10:15–11:15 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Laura's House Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members/community
3/30 5–6 p.m.	**CalOptima Health Medi-Cal Overview Presentation in English** James Guinn Elementary School Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members/community
April 2023			
4/3 2:30–3:30 p.m.	**CalOptima Health Medi-Cal Overview Presentation in Spanish** Troy High School 2200 Dorothy Ln., Fullerton	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
4/4 10–11 a.m.	**CalOptima Health Medi-Cal Overview Presentation in Spanish** La Vista High School 909 N. State College Blvd., Fullerton	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
4/5 4–6:30 p.m.	**Breathe Healthy Live Mindfully hosted by Anaheim Anti-Vaping Endeavor †** Gilbert High School	At least two staff members attended (in-person).	• Health/resource fair • Open to the public

* CalOptima Health-hosted
† Exhibitor/Attendee

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	1800 W. Ball Rd., Anaheim		
4/8 8 a.m.–Noon	**Spring Family Eggstravaganza hosted by the City of La Habra†** La Bonita Park 1440 W. Whittier Blvd., La Habra	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
4/13 4–5:30 p.m.	**Anaheim Mobile FRC hosted by Neighborhood and Human Services†** Sage Park 1313 Lido Pl., Anaheim	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
4/13 5– 7p.m	**Open House hosted by Walton Intermediate School†** Walton Intermediate School 12181 Buaro St., Garden Grove	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
4/15-4/16 10a.m– 5p.m.	**OC Dia del Nino hosted by Arts of OC†** OC Fair and Event Center **88 Fair Dr., Costa Mesa**	At least four staff members to attend (in-person).	• Health/resource fair • Open to the public
4/18 6:30– 7:30p.m	**CalOptima Health Medi-Cal Overview Presentation in English** Fristers Virtual	At least one staff member to present.	• Community-based organization presentation • Open to members/community
4/25 9–10:30 a.m.	**Cafecito Meeting*** Virtual	At least six staff members to attend.	• Steering committee meeting • Open to collaborative members
4/27 5– 6:30 p.m.	**Open House hosted by Heideman Elementary School†** Robert Heideman Elementary School 15571 Williams St., Tustin	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
4/29 11 a.m.– 4 p.m.	**Second Annual Family Fest hosted by The Wellness & Prevention Center†** Jim Johnson Memorial Sports Park 450 W. Avenida Vista Hermosa, San Clemente	At least two staff members to attend (in-person). Sponsorship fee: $2,500; includes resource table at event, logo on all promotional publications and media, goodie bag item for participants, post on Facebook event page, logo on all staff/volunteer t-shirts, and 40 carnival booth game tickets.	• Health/resource fair • Open to the public
4/29 10a.m– 5p.m.	**OC Dia del Nino hosted by Arts of OC†** Pacific Drive Elementary School 1501 W. Valencia Dr., Fullerton	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
4/29 10 a.m.–2 p.m.	**Spring Boutique and Health Fair hosted by the City of Anaheim†** Downtown Community Center 250 E. Center St., Anaheim	At least one staff member to attend (in-person). Registration fee: $125; includes resource table at the event.	• Health/resource fair • Open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

* CalOptima Health-hosted
† Exhibitor/Attendee

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
12. Approve Amendments to the CalOptima Health Bylaws

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Action
Approve amendments to the CalOptima Health Bylaws, effective April 6, 2023.

Background
The CalOptima Health Bylaws (Bylaws) were formally adopted by the CalOptima Health Board of Directors (Board) on December 6, 1994. The Bylaws set forth the Board's purpose and provide direction to its proceedings. They also provide for the establishment of Board Committees and advisory committees. On August 4, 2022, the Board approved amendments to the Bylaws to modernize the Bylaws and make them consistent with similar public agency health plans. Specifically, the amendments:

- Prohibited a director who is also a county Supervisor from employment by CalOptima Health for a period of one year after the director leaves the Board; and
- Expanded the authority of the Chief Executive Officer to resolve claims in lawsuits, demands or arbitration matters.

Discussion
Staff recommends amending the Bylaws to restate and conform to existing law related to conflict of interest, as follows:

- In addition to clarifying language, add a new subsection 12.2(a) as outlined below, and renumber existing sections to follow sequentially:

12.2 ~~No~~ Disqualifying Interest in Contracts.

a. Pursuant to Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, a Director shall not be financially interested in any contract made by the Director in their official capacity, or by the Board. Nor shall a Director be a purchaser or vendor at any sale or purchase made by them in their official capacity.

In addition to the material changes above, staff recommends conforming reference and formatting edits.

Fiscal Impact
There is no fiscal impact.

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Rationale for Recommendation
The recommended amendments update to the Bylaws conform with existing law.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Amended Bylaws (Redline and Clean Versions)
2. CalOptima Health Board Action, August 4, 2022, Approve Amendments to CalOptima Bylaws

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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ADOPTED: December 6, 1994
Amended and Revised August 4, 2022
Amended and Revised April 6, 2023

BYLAWS
OF
ORANGE COUNTY HEALTH AUTHORITY
ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, ~~CALOPTIMA HEALTH~~ CalOptima Health (CalOptima) ~~(CALOPTIMA)~~

ARTICLE I
DEFINITIONS

1.1 "Ad Hoc Committee" means a committee or work group composed solely of Directors which are less than a quorum of the Board, which does not have continuing subject matter jurisdiction, and does not have a meeting schedule fixed by charter, ordinance, Resolution or other formal action of the Board.

1.2 "Board" means the Board of Directors of ~~CalOPTIMA~~CalOptima.

1.3 "Board of Supervisors" means the Board of Supervisors of the County of Orange.

1.4 "Brown Act" means the Ralph M. Brown Act (Gov. Code § 54950 et. seq.).

1.5 "Bylaws" means the bylaws of ~~CalOPTIMA~~CalOptima.

1.6 "Chair" means the Chairperson of the Board of Directors.

1.7 "Chief Executive Officer" means the non-Board officer designated in Section 9.1 of these Bylaws.

1.8 "Committee" shall include both committees and subcommittees of the Board, unless otherwise specified. "Committee" shall not include "Ad Hoc Committees." The Advisory Committees specified in Section 4-11-15 of the Ordinance are Committees.

1.9 "County" means the County of Orange.

1.10 "Director" means a member of the Board of Directors of ~~CalOPTIMA~~CalOptima.

1.11 "~~CalOPTIMA~~CalOptima" means the Orange County Health Authority, doing business as Orange Prevention and Treatment Integrated Medical Assistance, doing business as CalOptima Health.

1.12 "Ordinance" means Ordinance No. 3896 of the County of Orange, adding Division 11 to Title 4 of the codified ordinances of the County of Orange.

1.13 "Resolution" means any action taken by the Board which requires a vote and is thereafter evidenced in the Board meeting minutes.

ARTICLE II
ORGANIZATION, POWERS AND PURPOSES

2.1 Authority.

a. These Bylaws are adopted by ~~CalOPTIMA~~CalOptima to establish rules for its proceedings pursuant to the authority of Section 4-11-13 of the Ordinance. ~~CalOPTIMA~~CalOptima is a local public agency and political subdivision of the State of California created by the Ordinance, pursuant to authority for such creation conferred by Welfare and Institutions Code section 14087.54.

b. ~~CalOPTIMA~~CalOptima is an entity separate and distinct from the County. Any obligations of ~~CalOPTIMA~~CalOptima, statutory, contractual or otherwise, shall be the obligations solely of ~~CalOPTIMA~~CalOptima and shall not be the obligations of the County or of the State of California unless expressly provided for in a contract between ~~CalOPTIMA~~CalOptima and the County or State of California.

2.2 Purposes.

The purposes of ~~CalOPTIMA~~CalOptima are as set forth in the Ordinance.

2.3 Powers.

a. ~~CalOPTIMA~~CalOptima shall have and enjoy all rights, powers, duties, privileges and immunities vested in the County pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, Part 3 of Division 9 of the Welfare and Institutions Code, and shall have and enjoy such other rights, powers, duties, privileges and immunities as provided in applicable law or which are necessary and proper to carry out the purposes of ~~CalOPTIMA~~CalOptima.

b. Without limiting the generality of Section 2.3(a), ~~CalOPTIMA~~CalOptima shall have the right to:

(1) Acquire, possess and dispose of real or personal property, as may be necessary for the performance of its functions.

(2) Contract for services to meet its obligations.

(3) Employ personnel.

(4) To sue and be sued.

(5) To adopt a seal and file such seal with the office of the County Clerk and

Secretary of State.

(6) Borrow such funds as may be necessary and proper.

(7) Other powers as may be specified in the Ordinance and by other provisions of law.

ARTICLE III
OFFICES

3.1 Principal Office.

The principal office for the transaction of business of ~~CalOPTIMA~~CalOptima shall be fixed and located at a location within the County designated by the Board.

ARTICLE IV
BOARD OF DIRECTORS

4.1 Powers.

The Board of Directors is the governing body of ~~CalOPTIMA~~CalOptima. Except as otherwise provided by the Ordinance or these Bylaws, the powers of ~~CalOPTIMA~~CalOptima shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board. The Board may delegate the management of ~~CalOPTIMA~~CalOptima's activities to any person(s) or Committees, however composed, provided that all the activities and affairs of ~~CalOPTIMA~~CalOptima shall be managed and all powers shall be exercised under the ultimate direction of the Board. No assignment, referral or delegation of authority by the Board shall preclude the Board from exercising full authority over the conduct of ~~CalOPTIMA~~CalOptima' s activities, and the Board may rescind such assignment, referral or delegation at any time.

4.2 Number and Qualifications of Directors.

The number and qualifications of Directors are as set forth in the Ordinance.

4.3 Term of Office.

a. The Board of Supervisors shall establish the term of office for the Director who is also a member of the Board of Supervisors, which term shall not exceed four years or other length of time established by amendment to Section 4-11-12 of the Ordinance.

b. The term of office for the Directors who are not also members of the Board of Supervisors shall be four (4) years; provided, however, that the terms of the original Directors shall be staggered to provide that one-half of those original Directors shall serve a term of three (3) years and the other half shall serve a full term of four (4) years to ensure continuity of policy. The initial appointment terms for such Directors shall be drawn by lots.

c. Directors may serve for a maximum of two (2) terms.

d. An orientation shall be provided which familiarizes each new Director with their duties and responsibilities.

e. In accordance with the Brown Act, any person appointed to serve as a Director who has not yet assumed the duties of their office shall conform their conduct to the requirements of Article 5 below.

4.4 Attendance and Participation.

a. Directors must attend the regular and special meetings of the Board and of Committees to which they are appointed and shall contribute their time and special abilities as may be required for the benefit of ~~CalOPTIMA~~CalOptima. If a Director is unable to attend a meeting, he or she shall so inform the Clerk giving the reason therefor, and the Clerk shall in turn inform the Chair who may rule in their sole and absolute discretion that the absence shall be excused. Alternatively, the Chair may recommend to the Board that the absence be deemed unexcused, and the Board shall make the final determination as to whether the absence shall be excused.

b. Failure of a Director to attend a regular or special meeting of the Board, or of Committees to which he or she is appointed, without first notifying the Clerk of an inability to attend the meeting shall, except in cases of emergency or extreme hardship (as determined by the Chair in their sole absolute discretion), be treated as an unexcused absence.

4.5 Vacancies.

With the exception of the Director appointed by the Board of Supervisors who is also a County Supervisor, appointments to the Board are based on the Director's representation of a particular group, such as health care providers or other organizations. A seat on the Board shall become vacant if a Director no longer is a member of, no longer represents, the group that qualified the Director for an appointment to the Board, or otherwise is no longer eligible under applicable law to serve as a Director. Vacancies shall be filled by the Board of Supervisors for the remainder of the unexpired term in accordance with the Ordinance.

4.6 Resignation and Removal.

a. Any Director may be removed from office by a majority vote of the Board of Supervisors favoring such removal.

b. Any Director may resign effective upon giving written notice to the Chair, the Clerk of the Board, and the Clerk of the Board of Supervisors, unless the notice specifies a later time for the effectiveness of such resignation.

c. If a Director has unexcused absences from three consecutive regular meetings or from three of any five consecutive meetings of the Board, the Board may pass a Resolution which recommends that the Board of Supervisors immediately remove such Director from the Board and appoint a successor to fill the remainder of the unexpired term.

4.7 Expenses.

Board members shall be reimbursed for their reasonable traveling, incidental and other expenses, when traveling outside the County, and incurred in the performance of official business of ~~CalOPTIMA~~CalOptima, in accordance with a policy as approved by the Board.

4.8 Prohibition on ~~CalOptima~~CalOptima Employment

A Director who is also a member of the Board of Supervisors may not be employed by ~~CalOptima~~CalOptima for a period of one year after the Director's term expires, or after the Director resigns or is removed from the Board.

ARTICLE V
BOARD MEETINGS

5.1 Board Meeting.

a. A meeting of the Board is any congregation of a majority of the Directors at the same time and place to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board.

b. A meeting of the Board is also the use of direct communication, personal intermediaries or technological devices that are employed by a majority of the Directors to develop a collective concurrence as to action to be made on an item by the Directors.

c. A meeting of the Board shall not be construed to exist when any of the following occur:

(1) A Director makes individual contact with any person not a Director.

(2) The attendance of a majority of the Directors at a conference or similar gathering open to the public that involves a discussion of issues of general interest to the public or to public agencies with similar functions or interests as ~~CalOPTIMA~~CalOptima, provided that a majority of the Directors do not discuss among themselves business of a specific nature that is within ~~CalOPTIMA~~CalOptima's subject matter jurisdiction.

(3) The attendance of a majority of the Directors at an open and publicized meeting organized to address a topic of local community concern by a person or organization other than ~~CalOPTIMA~~CalOptima, provided that a majority of the Directors do not discuss among themselves business of a specific nature that is within ~~CalOPTIMA~~CalOptima's subject matter jurisdiction.

(4) The attendance of a majority of the Directors at an open and noticed meeting of the legislative body of another local public agency, provided that a majority of the Directors do not discuss among themselves, other than as part of the schedule meeting, business of a specific nature that is within ~~CalOPTIMA~~CalOptima's subject matter jurisdiction.

(5) The attendance of a majority of the Directors at a purely social or ceremonial occasion, provided that a majority of the Directors do not discuss among themselves business of a specific nature that is within ~~CalOPTIMA~~CalOptima's subject matter jurisdiction.

5.2 Regular Meetings.

a. Regular meetings of the Board shall be held at a location as may be designated by Board action from time to time by the Board.

b. The Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. At the annual organizational meeting, the Board shall:

(1) Adopt a schedule stating the dates, times and places of the Board's regular meetings for the following year. A tentative proposed schedule for the Board's regular meetings shall have been distributed at the regular Board meeting preceding the organizational meeting.

(2) Organize itself by the election of one of its Directors as Chair and one as Vice Chair, and by the election of such other officers as the Board may deem appropriate.

5.2 Notice and Meeting; Agendas.

a. The Chief Executive Officer shall prepare, or cause to be prepared, an agenda for every regular and special meeting of the Board, which shall set forth the time and location of the meeting, and a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of the item generally need not exceed twenty (20) words.

b. At least 72 hours before a regular meeting, the Chief Executive Officer shall cause to be posted the agenda for the meeting in a location that is freely accessible to members of the public.

c. Action may be taken by the Board only on items appearing on the posted agenda. "Action taken" means a collective decision, collective commitment or promise made by a majority of the Directors to make a positive or negative decision, or an actual vote by a majority of the Directors upon a motion, proposal, Resolution or order. No action shall be taken on any item not appearing on the posted agenda, unless one of the following conditions exists:

(1) The Board has determined, by a majority vote, that an emergency situation exists. An emergency situation, for purposes of these Bylaws, means either: (a) a work stoppage

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or other activity which severely impairs public health, safety, or both, or (b) a crippling disaster which severely impairs public health, safety, or both.

(2) Upon a determination by a two-thirds vote of the Board, or, if less than two-thirds of the Directors are present, a unanimous vote of those Directors present, that there is a need to take immediate action and that the need for action came to the attention of the Board subsequent to the agenda being posted.

(3) The item was posted, as required above, for a prior meeting of the Board occurring not more than five calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which the action is being taken.

(4) The Board may briefly respond to statements made or questions posed by the public at the meeting. In addition, on its own initiative, or in response to questions posed by the public, the Board may ask a question for clarification, provide a reference to staff or other resources for factual information, or request staff to report back to the Board at a subsequent meeting. Furthermore, a Director or the Board itself may take action to place a matter of business on a future agenda.

d. Except as specified in Sections 5.3(d)(l) and 5.5(b) below, the Clerk shall give mailed notice of every regular meeting, and any special meeting which is called, at least one week prior to the date set for the meeting, to any person who has filed a written request for such notice with the Board.

(1) The Board may give such notice as it deems practical of special meetings called less than seven (7) days prior to the date set for the meeting, or in the case of an emergency meeting, telephonic notice in accordance with Section 5.5(b).

(2) Any request for notice shall be valid for one (1) year from the date on which it is filed unless a renewal request is filed. Renewal requests for notice shall be filed within ninety (90) days after January I of each year. The Board may establish by Resolution a reasonable annual charge for sending such notice based on the estimated cost of providing such service.

5.4 Members of the Public.

a. Every agenda for regular meetings shall provide an opportunity for members of the public to directly address the Board on items of interest to the public that are within the subject matter jurisdiction of the Board, provided that no action shall be taken on any item not appearing on the agenda unless the action is otherwise authorized by section 5.3.

b. The Chair may adopt reasonable regulations to ~~insure~~ensure that the intent of this section is carried out, including, but not limited to, regulations limiting the total amount of time allocated for public testimony on particular issues and for each individual speaker. If further public discussion and comment is needed on a particular issue, the Board may vote to allot further time in the same meeting, or allot time in the agenda of the following meeting.

c. Members of the public shall not be required, as a condition of attendance at a Board meeting, to register their name or provide other information. If an attendance list, register or other similar document is posted or circulated at the meeting, it shall state clearly that the signing, registering or completion of the document is voluntary and that all persons may attend the meeting regardless of whether a person does so.

d. The Board shall not prohibit public criticism of the policies, procedures, programs or services of ~~CalOPTIMA~~CalOptima or the acts or omissions of the Board or its officers, employees and/or consultants.

5.5 Special Meetings.

a. A special meeting may be called at any time by the Chair, or by four Directors, by delivering personally or by mail written notice to each Director and to each local newspaper of general circulation, radio or television station requesting notice in writing.

(1) Such notice must be delivered personally or by mail at least 24 hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the special meeting and the business to be transacted. No other business shall be considered at special meetings.

(2) The call and notice shall also be posted at least 24 hours prior to the special meeting in a location that is freely accessible to members of the public. Notice shall be required pursuant to this section 5.5 regardless of whether any action is taken at the special meeting.

(3) Such written notice may be dispensed with as to any Director who, at or prior to the time the meeting convenes, files with the Clerk a written waiver of notice. Such waiver may be given by telegram. Such written notice may also be dispensed with as to any Director who is actually present at the meeting at the time it convenes.

b. In the case of an emergency situation involving matters upon which prompt action is necessary due to the disruption or threatened disruption of public facilities, the Board may hold an emergency meeting without complying with either the 24-hour notice requirement or the 24-hour posting requirement, or both requirements. For purposes of this section, "emergency situation" shall have the same meaning as in Section 5.3(c)(l).

(1) In the event the notice and/or posting requirements are dispensed with due to an emergency situation, each local newspaper of general circulation and radio or television station which has requested notice of special meetings shall be notified by the Chair, or their designee, one hour prior to the emergency meeting, by telephone. All telephone numbers provided in the most recent request of such newspaper or station for notification of special meetings shall be exhausted. In the event that telephone services are not functioning, the notice requirements of this paragraph shall be deemed waived, and the Board, or its designee, shall notify those newspapers, radio stations or television stations

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of the fact of the holding of the emergency meeting, the purpose of the meeting, and any action taken at the meeting as soon after the meeting as possible.

(2) Notwithstanding Section 5.8(b) of these Bylaws, the Board shall not meet in closed session during a meeting called as an emergency meeting. With the exception of the 24-hour notice and posting requirements, all special meeting requirements prescribed in this section shall be applicable to a meeting called due to an emergency situation.

(3) The minutes of a meeting called due to an emergency situation, a list of persons who the Chair, or his designee, notified or attempted to notify, a copy of the roll call vote, and any actions taken at the meeting shall be posted for a minimum of ten days in a public place as soon after the meeting as possible.

5.6 Quorum and Action at Board Meeting.

a. A majority of the Directors shall constitute a quorum for the transaction of business. Except as otherwise provided by law or these Bylaws, the act of a majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board. No act of the Board shall be valid unless at least a majority of those Directors constituting a quorum concur therein. Any act of the Board shall be accomplished by a roll call vote when such a vote is requested by any Director in attendance. The Board shall not take action by secret ballot, whether preliminary or final.

b. The Board shall adopt a form of agenda for its regular and special meetings which may include consent, individual action, public, and board comments sections.

c. Items on the meeting agenda shall be considered in order by the Board unless the Chair shall announce a change in the order of consideration.

d. Unless an agenda item specifies a particular source for a report, the Chief Executive Officer, Board staff and consultants shall report first on the item. The item shall then be open to public comment upon recognition of the speaker by the Chair.

e. A Director shall disqualify himself or herself from voting on any matter before the Board, and shall take further appropriate action to remove himself or herself from Board consideration of any such matter, when required pursuant to the provisions of Article XII of these Bylaws or applicable law.

5.7 Adjournment and Continuance.

a. The Board may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If no Directors are present at a meeting, the Clerk may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in section 5.5 of these Bylaws for special meetings, unless such notice

is waived as provided for special meetings.

b. A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the meeting was held within 24 hours after the time of the adjournment. When a regular or adjourned regular meeting is adjourned as provided in this section, the resulting adjourned regular meeting is a regular meeting for all purposes.

c. The Board may continue any hearing being held or noticed or ordered to be held at any meeting to a subsequent meeting by order or notice of continuance provided in the same manner as set forth above for the adjournment of meetings; provided, that if the meeting is continued to a time less than 24 hours after the time specified in the order or notice of hearing, a copy of the order or notice of continuance of hearing shall be posted immediately following the meeting at which the order or declaration of continuance was adopted or made.

5.8 Public Meetings.

a. Meetings of the Board shall be open to the public, except as otherwise provided herein.

b. The Board may hold closed sessions during a meeting for the following purposes:

(1) To consider the appointment, employment, evaluation of performance or dismissal of a public employee or to hear complaints or charges brought against the employee by another person or employee unless the employee requests a public session. As a condition to holding a closed session on specific complaints or charges brought against an employee by another person or employee, the employee shall be given written notice of their right to have the complaint or charges heard in an open session rather than a closed session, which notice shall be delivered to the employee personally or by mail at least 24 hours before the time for holding the session. If notice is not given, any disciplinary or other action taken by the Board against the employee based on the specific complaints or charges in the closed session shall be null and void. The Board may exclude from that public or closed meeting, during the examination of a witness, any or all other witnesses in the matter being investigated by the Board. The term "employee" shall include an officer or an independent contractor who functions as an officer or an employee but shall not include any Director or other independent contractor. During the closed session, the Board shall not discuss or act on an employee's proposed compensation except for a reduction of compensation that results from the imposition of discipline.

(2) To meet with its designated representatives regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits of its represented and unrepresented employees and for represented employees, any other matter within the statutorily-provided scope of representation. "Employee" shall have the same meaning for this closed session as described in section 5.8(b)(l) above. During the closed session, the Board may include discussions with ~~CalOPTIMA~~CalOptima's designated representatives of ~~CalOPTIMA~~CalOptima's available funds and funding priorities, but only as these discussions relate

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to providing instructions to the designated representatives.

(3) To meet with its negotiator prior to the purchase, sale, exchange, or lease of real property by or for ~~CalOPTIMA~~CalOptima, or to give instructions to its negotiator regarding the price and terms of payment for the purchase, sale, exchange, or lease. However, prior to the closed session, the Board shall hold an open and public session in which it identifies the real property or real properties which the negotiations may concern and the person or persons with whom its negotiator may negotiate. For the purposes of this section, the negotiator may be a Director, and "lease" includes renewal or renegotiation of a lease.

(4) Based on advice of its legal counsel, to confer with, or receive advice from, its legal counsel regarding pending litigation when discussion in open session concerning those matters would prejudice the position of ~~CalOPTIMA~~CalOptima in the litigation. Prior to holding a closed session pursuant to this section, the Board shall state on the agenda or publicly announce the subdivision of Government Code section 54956.9 that authorizes the closed session. If the session is closed because of litigation to which ~~CalOPTIMA~~CalOptima is a party has been formally initiated, the Board shall state the title of or otherwise specifically identify the litigation to be discussed, unless the Board states that to do so would jeopardize ~~CalOPTIMA~~CalOptima~~'~~s ability to effectuate service of process upon one or more unserved parties, or that to do so would jeopardize its ability to conclude existing settlement negotiations to its advantage. For purposes of this section, "litigation" includes any adjudicatory proceeding, including eminent domain, before a court, administrative body exercising its adjudicatory authority, hearing officer, or arbitrator. For purposes of this section, litigation shall be considered pending when any of the following circumstances exist:

(a) Litigation to which ~~CalOPTIMA~~CalOptima is a party has been formally initiated.

(b) (i) A point has been reached where, in the opinion of the Board on the advice of its legal counsel, based on existing facts and circumstances, there is significant exposure to litigation against ~~CalOPTIMA~~CalOptima, or

(ii) based on existing facts and circumstances, the Board is meeting only to decide whether a closed session is authorized under subparagraph (b)(l) above.

(c) Based on existing facts and circumstances, the Board has decided to initiate or is deciding whether to initiate litigation.

(5) Any other closed session authorized pursuant to applicable state or federal law or regulation.

c. Prior to holding any closed session, the Board must disclose, in an open meeting, the item or items to be discussed in the closed session. The Board may use the sample closed session agenda descriptions contained in the Brown Act (Gov. Code § 54954.5). The disclosure may take the form of a reference to the item or items as they are listed by number or letter on the

agenda. In the closed session, only those matters covered in the statement can be considered by the Board.

d. After any closed session, the Board shall reconvene into open session prior to adjournment and shall make any disclosures required by the Brown Act concerning final actions.

5.9 Disrupted Meetings.

In the event that any meeting is interrupted by a group or groups of persons rendering the orderly conduct of such meeting unfeasible, and order cannot be restored by the removal of individuals who were willfully interrupting the meeting, the Board may order the meeting room closed and continue in session. Only matters appearing on the agenda may be considered in such a session. Representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this section. The Board may establish a procedure for readmitting an individual or individuals not responsible for willfully disrupting the orderly conduct of the meeting.

5.10 Minutes.

The Clerk or designee shall prepare minutes of each meeting of the Board. Except as otherwise provided in the Brown Act for minutes of closed sessions, the minutes shall be an accurate summary of the Board's consideration of the matters before it and an accurate record of each action of the Board. Except for minutes of closed sessions, at a subsequent meeting, the Clerk shall submit the minutes to the Board for approval by a majority vote of the Directors in attendance at the meeting covered by the minutes. When approved, copies of the minutes shall be forwarded by the Clerk or designee to the Chief Executive Officer.

ARTICLE VI
BOARD COMMITTEES

6.1 Establishment: Appointment of Committee Members.

a. All Committees shall be established by these Bylaws or by Board action, and shall be established for any purpose as the Board deems necessary or beneficial in accomplishing the purposes of ~~CalOPTIMA~~CalOptima.

b. Committees shall be subject to the requirements of the Brown Act.

c. The Chair may designate alternate members of any Committee to stand in for any absent Director at any meeting of the Committee. The chair of each Committee shall be appointed by the Chair of the Board, except that the Chair of each of the Advisory Committees shall be elected by the Board

d. All Committees shall be advisory only to the Board unless otherwise specifically authorized to act by the Board.

6.2 Ad Hoc Committees.

a. Ad Hoc Committees may be appointed by the Chair for special tasks as circumstances warrant, and shall be composed solely of Directors, and upon completion of the task for which appointed, such Ad Hoc Committee shall stand discharged. Some of the functions that may be the topic of Ad Hoc Committees include, but are not limited to, the review of new projects, the review of special Bylaw changes or the review of the Bylaws periodically, meeting with other public agencies or health facilities on a specific topic, and the evaluation of the Board.

b. The Chair shall make assignments to Ad Hoc Committees to assure that each Director shall have equal participation on Ad Hoc Committees throughout the year.

c. Ad Hoc Committees shall always be advisory in nature.

6.3 Advisors.

A chair of a Committee or an Ad Hoc Committee may invite individuals with expertise in a pertinent area to meet with and assist the Committee or Ad Hoc Committee. Such advisors shall not vote or be counted in determining the existence of a quorum and may be excluded from any Committee session not otherwise open to the public.

6.4 Meetings and Notice.

a. Regular meetings of Committees shall be held at such times and places as are determined by the Board. Special meetings of Committees may be held at any time and place as may be designated by the Chair or the chair of the Committee, or by a majority of the voting members of the Committee.

b. Regular and special meetings of a Committee shall be noticed in accordance with sections 5.3 and 5.5, respectively, of these Bylaws.

c. Meetings of Ad Hoc Committees shall be noticed as directed by the chair of the Ad Hoc Committee.

6.5 Quorum.

A majority of the members of a Committee or Ad Hoc Committee shall constitute a quorum for the transaction of business at any meeting of such Committee or Ad Hoc Committee. Each Committee and Ad Hoc Committee shall keep minutes of its proceedings and shall report periodically to the Board.

6.6 Manner of Acting.

The act of a majority of the members of a Committee or Ad Hoc Committee present at a meeting at which a quorum is present shall be the act of the Committee or Ad Hoc Committee so meeting. Regular and special meetings of Committees shall be conducted in accordance with

applicable provisions of Article V of these Bylaws. Ad Hoc Committee action may be taken without a meeting by a writing setting forth the action so taken signed by each member of the Ad Hoc Committee entitled to vote.

6.7 Tenure.

Each member of a Committee or Ad Hoc Committee shall hold office until a successor is appointed. Any member of an Ad Hoc Committee may be removed at any time by the Chair. The Board may remove any member of a Committee. A Director shall cease to hold membership in an Ad Hoc Committee upon ceasing to be a Director.

6.8 Minutes.

The Clerk or designee shall prepare minutes of each meeting of every Committee. The minutes shall accurately summarize the consideration of all matters, and shall accurately record all action taken. At a subsequent meeting, the Clerk shall submit the minutes to the Committee for approval by a majority vote of the members in attendance at the meeting covered by the minutes. When approved, copies of the minutes shall be forwarded by the Clerk to the Board and Chief Executive Officer.

ARTICLE VII
ADVISORY COMMITTEES

7.1 Establishment.

a. The Board may establish and appoint Advisory Committees for any purpose that will be necessary and beneficial in accomplishing the work of ~~CalOPTIMA~~CalOptima, in a number and with qualifications as set forth in the Resolution of the Board establishing the Advisory Committee or the policy governing such Advisory Committee.

b. The following Advisory Committees are hereby established and appointed:

1. Provider Advisory Committee.

2. Member Advisory Committee.

7.2 Purpose.

Advisory Committees of ~~CalOPTIMA~~CalOptima shall be solely advisory in nature. As directed by the Board they are:

(1) Intended to provide advice and recommendations to the Board on issues concerning the ~~CalOPTIMA~~CalOptima program.

(2) To engage in study and research on issues assigned to them by the Board.

(3) To assist the Board in obtaining public opinion on issues related to the ~~CalOPTIMA~~CalOptima program.

(4) To facilitate community outreach for ~~CalOPTIMA~~CalOptima and the Board.

7.3 Policy

The Board shall by Resolution adopt and, from time to time may amend, a policy setting forth member qualifications, requirements for meetings (including compliance with the Brown Act), items of procedure, and other matters relating to the overall operations and purposes of Advisory Committees established by the Board.

ARTICLE VIII
OFFICERS OF THE BOARD OF DIRECTORS

8.1 Chair.

a. The Board shall elect one of its Directors as Chair at an organizational meeting. In the event of a vacancy in the office of Chair, the Board may elect a new Chair.

b. The Chair shall be the principal officer of the Board, and shall preside at all meetings of the Board. The Chair shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. In addition, the Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

8.2 Vice Chair.

The Board shall elect one of its Directors as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act. If both the Chair and Vice Chair are absent from the meeting, or are unable to act, the Directors present at the meeting shall select one of the Directors present to act as temporary Chair, who, while so acting, shall have all of the authority of the Chair.

8.3 Tenure.

Each officer described above in this Article VIII shall serve a one (1) year term, commencing on the first day of the month after the organizational meeting at which he or she is elected to the position. Each officer shall hold office until the end of the one (1) year term, or until a successor is elected, unless he or she shall sooner resign or be removed from office.

8.4 Vacancies, Removal and Resignation.

a. A vacancy in any office for any cause whatsoever shall be filled by Resolution of the Board at any regular or special meeting of the Board.

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b. An officer described above may be removed from office by the affirmative vote of four Directors, not counting the affected Director. In addition, an officer described above will automatically be removed from office when their successor is selected and is appointed as a Director.

c. Any officer may resign effective on giving written notice to the Clerk, unless the notice specifies a later time for their resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chair thereof and shall enter the notice in the proceedings of the Board.

8.5 Other Officers.

The Board may designate such other officers of the Board as the Board may from time to time determine that ~~CalOPTIMA~~CalOptima requires and may elect one of its Directors to discharge the duties of any such office.

ARTICLE IX
OTHER OFFICERS

9.1 Chief Executive Officer.

a. The Board shall select and employ a Chief Executive Officer, who shall report to the Board and who shall be the Board's direct executive representative in the development and management of the affairs of ~~CalOPTIMA~~CalOptima. The Chief Executive Officer shall serve at the pleasure of the Board, subject to the provisions of any contract of employment between ~~CalOPTIMA~~CalOptima and the Chief Executive Officer.

b. The Chief Executive Officer shall have such duties and responsibilities as the Board may from time to time reasonably direct. Without limiting the generality of the foregoing, the Chief Executive Officer shall be responsible for:

(1) Implementing the policies, procedures and practices of ~~CalOPTIMA~~CalOptima as adopted by the Board.

(2) Acting as the duly authorized representative of ~~CalOPTIMA~~CalOptima in all matters in which the Board has not formally designated some other person to act.

(3) Managing and directing the operations of ~~CalOPTIMA~~CalOptima, including responsibility for sound personnel, financial, accounting, legal and statistical information practices, such as preparation of ~~CalOPTIMA~~CalOptima budgets and forecasts, maintenance of proper financial and other statistical records, collection of data required by governmental and accrediting agencies, and special studies and reports required for efficient operation of ~~CalOPTIMA~~CalOptima ~~problems~~.

(4) Providing leadership by promoting morale and resolving conflicts and problems

(5) Implementing community relations activities, including, public appearances, responsive communication with the media.

(6) Developing and maintaining positive ongoing relations with local, State and federal government officials and agencies.

(7) Assisting the Board in planning services and facilities and informing the Board of governmental legislation and regulations and requirements of official agencies and accrediting bodies, which affect the planning and operation of the facilities, services and programs sponsored by ~~CalOPTIMA~~CalOptima, and maintaining appropriate liaison with government and accrediting agencies and implementing actions necessary for compliance.

(8) Employing and discharging (subject to the pleasure of the Board, any contract of employment, and ~~CalOPTIMA~~CalOptima personnel employment policies), such subordinate officers and employees as are necessary for the purpose of carrying on the normal functions of ~~CalOPTIMA~~CalOptima.

(9) Administrating all contracts to which ~~CalOPTIMA~~CalOptima is a party.

(10) Providing the Board, Committees, and Ad Hoc Committees with adequate staff support.

(11) Sending periodic reports to the Board on the overall activities of ~~CalOPTIMA~~CalOptima and ~~CalOPTIMA~~CalOptima's finances and financial status, as well as pertinent federal, state and local developments that effect ~~CalOPTIMA~~CalOptima's operations.

(12) Maintaining insurance or self-insurance to cover the physical properties and activities of ~~CalOPTIMA~~CalOptima.

(13) Developing, amending, promulgating and implementing personnel policies for ~~CalOPTIMA~~CalOptima.

9.2 Chief Financial Officer.

a. The Chief Financial Officer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business or financial transactions of ~~CalOPTIMA~~CalOptima, shall prepare or cause to be prepared financial statements as law or these Bylaws require. The books of account shall at all times be open to inspection by any Director.

b. The Chief Financial Officer shall deposit all monies and other valuables in the name and to the credit of ~~CalOPTIMA~~CalOptima with depositories designated by the Board. The Chief Financial Officer shall disburse the funds of ~~CalOPTIMA~~CalOptima as ordered or authorized by the Board, shall render to the Chair and Directors, whenever they request it, an account of all transactions and of the financial condition of ~~CalOPTIMA~~CalOptima, and shall

have other powers and perform other

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duties as prescribed by the Board and/or the Chief Executive Officer.

9.3 Clerk.

a. The Clerk shall have the following duties:

(1) Keeping a book of the minutes of all meetings of the Board at the principal office of ~~CalOPTIMA~~CalOptima or other place ordered by the Board, and of its Committees.

(2) Giving or causing to be given appropriate notices in accordance with these Bylaws or as required by law.

(3) Attesting to the Chair's, Vice-Chair's, Chief Executive Officer's, or other authorized signatory's signature on documents executed on behalf of ~~CalOPTIMA~~CalOptima.

(4) Acting as custodian of ~~CalOPTIMA~~CalOptima's records and reports and of ~~CalOPTIMA~~CalOptima's seal, if one is adopted.

(5) Causing a statement meeting the requirements of Government Code section 53051 to be filed with the Secretary of State and the County Clerk to list ~~CalOPTIMA~~CalOptima on the "Roster of Public Agencies"; and causing an amended statement to be filed with the Secretary of State and County Clerk within ten (10) days of any change in the facts set forth in the original or a subsequently amended statement.

(6) Providing a copy of the Brown Act to each Director, and to each person appointed to serve as a Director who has not assumed the duties of office.

(7) Having such other duties as may be prescribed by Resolution of the Board or these Bylaws.

9.4 Subordinate Officers.

The Board may empower the Chief Executive Officer to select and employ such other non-Board officers as ~~CalOPTIMA~~CalOptima may require, each of whom shall hold office for such period, have such authority, and perform such duties as the Board or Chief Executive Officer may from time to time determine.

ARTICLE X
EXECUTION OF INSTRUMENTS

10.1 Contracts and Instruments.

a. The Board may authorize any officer or officers, agent or agents, employee or employees to enter into any contract or execute any instrument in the name of and on behalf of the Board, and this authority may be general or confined to specific instances; and, unless so

authorized or ratified by the Board, no officer, agent, or employee shall have any power or authority to bind ~~CalOPTIMA~~CalOptima by any contract or engagement or to render it liable for any purpose or for any amount.

b. Notwithstanding the foregoing Section 9.-l(a), the Chief Executive Officer is hereby authorized to enter into any contract or execute any instrument in the name of and on behalf of ~~CalOPTIMA~~CalOptima pursuant to policies established by the Board.

c. The Clerk shall have the authority to attest to the signatures of those individuals authorized to enter into contracts or execute instruments in the name of and on behalf of ~~CalOPTIMA~~CalOptima and to certify the incumbency of those signatures.

10.2 Checks, Drafts, Evidences of Indebtedness

All checks, drafts or other orders for payment of money, notes or other evidences issued in the name of or on behalf of ~~CalOPTIMA~~CalOptima or payable to the order of ~~CalOPTIMA~~CalOptima, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by Resolution of the Board.

ARTICLE XI
CLAIMS AND JUDICIAL REMEDIES

11.1 Claims

~~CalOPTIMA~~CalOptima is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public entities. The Chief Executive Officer or designee is authorized to perform those functions of the Board specified in Part 3 of that Division, including the allowance, compromise or settlement of any claims if the amount to be paid from ~~CalOPTIMA~~CalOptima's treasury does not exceed $50,000.00 per individual claim, or $300,000 total per lawsuit, demand, or arbitration matter. ~~action~~ Any allowance, compromise or settlement of any claim in which the amount to be paid form ~~CalOPTIMA~~CalOptima's treasury exceeds $10,000 per individual claim shall be approved personally by the Chief Executive Officer, rather than their designee.

Rev. 08/04/2022

11.2 Judicial Review

Section 1094.6 of the Code of Civil Procedure shall govern the rights of any person aggrieved by any decision of the Board or ~~CalOPTIMA~~CalOptima.

11.3 Claims Procedure

Notwithstanding any exceptions contained in Section 905 of the Government Code, no action based on a claim shall be brought against ~~CalOPTIMA~~CalOptima unless presented to ~~CalOPTIMA~~CalOptima within the time limitations and in the manner prescribed by Section 910 through 915.2 of the Government Code. Such claims shall further be subject to Section 945.4 of the Government Code.

ARTICLE XII
CONFLICTS OF INTEREST

12.1 Conflict of Interest Code.

The Board shall by Resolution adopt and, from time to time may amend, a Conflict of Interest Code for ~~CalOPTIMA~~CalOptima as required by applicable statutes and regulations.

12.2 ~~No~~ Disqualifying Interest in Contracts.

a. Pursuant to Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, a Director shall not be financially interested in any contract made by the Director in their official capacity, or by the Board. Nor shall a Director be a purchaser or vendor at any sale or purchase made by them in their official capacity.

~~a.~~b. Notwithstanding the foregoing Section 12.2(a), ~~A~~a Director shall not be deemed to be interested in a contract entered into by ~~CalOPTIMA~~CalOptima within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all of the following requirements set forth in Welfare and Institutions Code section 14087.57 apply:

~~a.~~ (1) The Director was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies or other health care organizations.

~~b.~~ (2) The contract authorizes the Director or the organization the member represents to provide services to Medi-Cal beneficiaries under ~~CalOPTIMA~~CalOptima's program.

~~c.~~ (3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals and organizations that the Director was appointed to represent.

~~d.~~ (4) The Director does not influence or attempt to influence the Board or another Director to enter into the contract in which the member is interested.

~~e.~~ (5) Director discloses the interest to the Board and abstains from voting on the contract.

~~f.~~ (6) The Board notes the Director's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested Director.

ARTICLE XIII

MISCELLANEOUS

13.1 Purchase, Hiring, and Personnel.

The Board shall by Resolution adopt and, from time to time may amend, procedures, practices and policies for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property and improvements, hiring employees, managing its personnel and for all other matters, in the determination of the Board, as are necessary and appropriate for the proper conduct of ~~CalOPTIMA~~CalOptima' s activities and affairs and the furtherance of its authorized purposes. Copies of all such procedures, practices and policies shall be maintained with the minutes of proceedings of the Board.

13.2 Insurance.

~~CalOPTIMA~~CalOptima shall procure and maintain property, casualty, indemnity and workers' compensation insurance, including without limitation directors' and officers' liability and professional liability coverage, in such amounts and with such carriers as the Board shall from time to time determine shall be prudent in the conduct of its activities; provided that the Board is authorized to arrange the provision of self-insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

13.3 Indemnification and Defense.

a. With respect to any civil claim or action against a Director, member of an Advisory Committee or Committee, officer, employee, or a person who formerly occupied such position, for an injury arising out of an act or omission occurring within the scope of such person's duties, ~~CalOPTIMA~~CalOptima shall indemnify, hold harmless and defend such persons to the full extent permitted or required under applicable sections of the California Tort Claims Act. (Gov. Code§ 810 et seq.; see, e.g. Gov. Code§§ 825, 825.2, 825.4, 825.6, 995.4, 995.6 and 995.8.)

b. Nothing herein shall be construed to require ~~CalOPTIMA~~CalOptima to indemnify and hold harmless any Director, member of an Advisory Committee or Committee, officer, employee, or a person who formerly occupied such position, if ~~CalOPTIMA~~CalOptima has elected to conduct the defense of such person(s) pursuant to an agreement reserving ~~CalOPTIMA~~CalOptima's rights not to pay a judgment, compromise or settlement until it is established that the injury arose out of an act or omission occurring within the scope of their duties with ~~CalOPTIMA~~CalOptima.

13.4 Bonds.

All Directors, as well as all officers, employees and agents or representatives of ~~CalOPTIMA~~CalOptima designated by the Board, shall obtain fidelity bonds as required by law and as the Board shall determine is prudent in the conduct of its activities and the activities of such officers, employees, and other designated agents or representatives of ~~CalOPTIMA~~CalOptima.

13.5 Public Records.

a. All documents and records of ~~CalOPTIMA~~CalOptima, not exempt from disclosure by applicable law, shall be public records under the California Public Records Act (Gov. Code § 6250 et seq.)

b. Any authorized representative of the County shall have the absolute right to inspect and copy all books, records and documents of every kind of ~~CalOPTIMA~~CalOptima to determine compliance with the provisions of Section 4-11-7 of the Ordinance, provided such inspection is conducted at a reasonable time following reasonable notice.

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13.6 Submission of Bylaws to Board of Supervisors.

The Clerk shall deliver a certified copy of these Bylaws, and any amendments thereto, to the Board of Supervisors.

13.7 Conflict Between Bylaws and Ordinance.

In the event of a conflict between these Bylaws and the Ordinance, the applicable provisions of the Ordinance shall govern.

ARTICLE XIV
AMENDMENT

These Bylaws may be amended or repealed by the affirmative vote of at least two- thirds (2/3) of the authorized number of Directors at any Board meeting. Such amendments or repeal shall be effective immediately, except as otherwise indicated by the Board. The Clerk shall deliver a certified copy of any amendment or repeal of these Bylaws to the Board of Supervisors promptly following the Board meeting at which such amendment or repeal was adopted.

CERTIFICATE OF CLERK

I, the undersigned, do hereby certify:

That I am the duly appointed, qualified and acting Clerk of the Board of Directors for Orange Prevention and Treatment Integrated Medical Assistance ("~~CalOPTIMA~~CalOptima"), a special commission of the County of Orange created pursuant to Section 14087 .54 of the Welfare and Institutions Code, and Ordinance No. 3896 of the County of Orange, and

That the foregoing Bylaws attached hereto, comprising ~~26~~ 23 pages, including this page, constitute a true, complete and correct copy of the current Bylaws of ~~CalOPTIMA~~CalOptima, as duly adopted by the Board of Directors of ~~CalOPTIMA~~CalOptima at a regular meeting, duly called and held on the _____ day of _____ at _____, California.

Dated: _____

_____
Clerk

ADOPTED: December 6, 1994
Amended and Revised August 4, 2022
Amended and Revised April 6, 2023

BYLAWS
OF
ORANGE COUNTY HEALTH AUTHORITY
ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, CalOptima Health (CalOptima)

ARTICLE I
DEFINITIONS

1.1 "Ad Hoc Committee" means a committee or work group composed solely of Directors which are less than a quorum of the Board, which does not have continuing subject matter jurisdiction, and does not have a meeting schedule fixed by charter, ordinance, Resolution or other formal action of the Board.

1.2 "Board" means the Board of Directors of CalOptima.

1.3 "Board of Supervisors" means the Board of Supervisors of the County of Orange.

1.4 "Brown Act" means the Ralph M. Brown Act (Gov. Code § 54950 et. seq.).

1.5 "Bylaws" means the bylaws of CalOptima.

1.6 "Chair" means the Chairperson of the Board of Directors.

1.7 "Chief Executive Officer" means the non-Board officer designated in Section 9.1 of these Bylaws.

1.8 "Committee" shall include both committees and subcommittees of the Board, unless otherwise specified. "Committee" shall not include "Ad Hoc Committees." The Advisory Committees specified in Section 4-11-15 of the Ordinance are Committees.

1.9 "County" means the County of Orange.

1.10 "Director" means a member of the Board of Directors of CalOptima.

1.11 "CalOptima" means the Orange County Health Authority, doing business as Orange Prevention and Treatment Integrated Medical Assistance, doing business as CalOptima Health.

1.12 "Ordinance" means Ordinance No. 3896 of the County of Orange, adding Division 11 to Title 4 of the codified ordinances of the County of Orange.

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Approve CalOptima Health's Calendar Years 2023 and 2024 Legislative Priorities and Authorize Related Advocacy Efforts

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

1. Approve CalOptima Health's calendar years 2023 and 2024 legislative priorities (Priorities);
2. Authorize the Chief Executive Officer (CEO), or designee, to:
    a. Implement legislative and regulatory advocacy efforts in alignment with the Priorities;
    b. Develop publications and other materials in furtherance of the Priorities for external distribution to policymakers and other stakeholders; and
    c. Provide regular progress reports regarding advocacy activities to the CalOptima Health Board of Directors (Board).

Background

As part of its Government Affairs program, CalOptima Health staff track and analyze federal, state, and local legislation that may impact CalOptima Health and its members, providers, and 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 Health.

To guide legislative and regulatory advocacy efforts and better represent CalOptima Health's interests in Sacramento and Washington, DC, staff developed the Priorities for consideration by the Board. When drafting the Priorities, staff solicited input from CalOptima Health executive leadership and department heads to ensure public policy objectives reflect current organizational goals, including the Board-approved 2022-2025 Strategic Priorities and related Tactical Priorities. In determining whether a policy objective should be included within the Priorities, staff consulted its contracted lobbyists and considered whether the objective was: (1) likely to require or be impacted by legislative and/or regulatory action; and (2) likely to be considered by a legislative or regulatory body in calendar years 2023 or 2024.

Discussion

Staff efforts and feedback identified 54 individual policy objectives for inclusion in the Priorities. The policy objectives were grouped into the following nine policy areas:

1. Behavioral Health
2. California Advancing and Innovating Medi-Cal (CalAIM)
3. Data Sharing
4. Financing
5. Older Adults
6. Operations and Administration
7. Provider Support
8. Quality Improvement
9. Social Determinants of Health (SDOH)

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Staff recommends Board adoption of the Priorities as well as authorization for the CEO, or designee, to implement legislative and regulatory advocacy efforts in furtherance of the Priorities. Such efforts may include authorizing CalOptima Health's formal positions on proposed legislation and regulations, executing letters of support and opposition to lawmakers and other government officials, meeting with such officials or their staff, and/or directing CalOptima Health's contracted lobbyists to advocate on the agency's behalf.

To facilitate such advocacy efforts, the CEO, or designee, would also be authorized to develop publications, handouts, and other materials that further explain or otherwise communicate the Priorities and any related advocacy positions and then externally distribute such materials to legislators, government officials, and their staffs, as well as community stakeholders.

Any recommendations for formal positions or related advocacy efforts that do not align with the adopted Priorities will be brought to the Board for future consideration.

Fiscal Impact
The recommended actions are operational in nature. To the extent there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future CalOptima Health operating budgets.

Rationale for Recommendation
Legislative and regulatory advocacy continues to be a priority for CalOptima Health given the level of activity on health care-related issues in the U.S. Congress, California State Legislature, and several federal and state agencies. Proactive engagement with trade associations, advocates, and elected officials is critical to influencing policy decisions that are likely to impact CalOptima Health in the next two years. Adoption of the Priorities will enable staff to be more strategic, focused, and effective in their advocacy efforts regarding the agency's policy objectives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health's 2023–24 Legislative Priorities

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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2023–24 Legislative Priorities

Behavioral Health

- Support improved parity between physical and mental health care, including rates and coverage of preventive services without diagnoses.
- Support stable, sustainable funding streams for behavioral health services.
- Increase funding for Medi-Cal member access to Be Well Orange County campuses.
- Remove barriers to accessing behavioral health services, including mobile crisis and telehealth-only.
- Incentivize all applicable providers to treat behavioral health conditions within their scope of service.
- Improve the system and capacity for complex discharge management of members with behavioral health diagnoses.
- Enhance integration between specialty and non-specialty Medi-Cal mental health services.
- Support policies to prevent and address substance use disorders, including medication access.

California Advancing and Innovating Medi-Cal (CalAIM)

- Allow health plan discretion to determine member and provider eligibility for Enhanced Care Management (ECM) and Community Supports (CS).
- Simplify pathway for Medi-Cal plans to develop and offer additional CS options to members.
- Incorporate CS into covered benefits to ensure long-term funding and sustainability.
- Invest in infrastructure, training and other supports to prepare providers for CalAIM initiatives.
- Support continuous Medi-Cal coverage for justice-involved individuals.
- Streamline health plan assessment and reporting requirements for CalAIM measures and outcomes.

Data Sharing

- Increase funding, guidance, timeline certainty and implementation flexibility for health care entities to launch data-sharing and infrastructure initiatives, including the Data Exchange Framework, interoperability and the expansion of and connection to regional health information exchanges (HIEs).
- Standardize and ease requirements for data sharing and consent management of health records across payors, providers and public agencies to improve care coordination.

Financing

- Oppose changes to current Medical Loss Ratio (MLR) methodology.
- Ensure Managed Care Organization (MCO) tax revenue prioritizes funding for the Medi-Cal program.
- Ensure future rate changes are beneficial to CalOptima Health and its contracted providers.
- Incorporate audio-only telehealth encounters into the calculation of Medicare risk adjustment payments.
- Reform the use of risk corridors by increasing transparency, accounting for administrative complexity and reducing the number of overlapping corridors.
- Preserve the use of intergovernmental transfer (IGT) funds to offer non-covered Medi-Cal and Medicare benefits.

Older Adults

- Promote overall integration of the Medi-Cal and Medicare programs.
- Support enrollment of full and partial dual-eligible beneficiaries into exclusively aligned enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).
- Align Medi-Cal and Medicare policies that limit the frequency of plan switching to improve continuity of care.
- Support the creation and sustainability of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) consistent with EAE D-SNP enrollment policies.
- Expand access to home- and community-based services, including the Program of All-Inclusive Care for the Elderly (PACE), for older adults, including those experiencing or at risk of homelessness.

- Preserve current flexibilities to virtually assess prospective and current PACE participants.
- Expand onsite access to COVID-19 vaccines at PACE facilities.
- Allow PACE organizations to utilize ride-sharing services to supplement transportation vendors.
- Increase PACE funding to address telehealth barriers, such as member access to devices, internet and training.

Operations and Administration

- Preserve the county-organized health system (COHS) and delegated managed care delivery models.
- Oppose requiring COHS to obtain a Knox-Keene Act license.
- Oppose the elimination or carving out of Medi-Cal managed care benefits, such as the Whole-Child Model (WCM).
- Promote efforts to advance health equity and reduce health disparities through current and future Medi-Cal and Medicare initiatives.
- Support 12-month continuous eligibility for all Medi-Cal beneficiaries.
- Reform Medi-Cal Rx policies to improve prior authorization and appeals processes.
- Incentivize health networks to implement same-day prior authorizations.
- Oppose policies that restrict health plan use of prior authorizations.
- Expand the ability for health plans to communicate with members to support care coordination.
- Implement clear, consistent and reasonable timelines for the implementation and evaluation of new covered benefits, programs, initiatives and audits.

Provider Support

- Increase Medi-Cal reimbursement rates, especially for behavioral health services and major organ transplants.
- Remove barriers to provider contracting, including expanding allowable provider types.
- Invest in the development of a diverse health care workforce, including training, education and certification programs, and remove barriers to program enrollment, completion and subsequent hiring.
- Invest in public health infrastructure to better prepare for future pandemics and other health crises.
- Permanently extend Medicare telehealth flexibilities enacted during the COVID-19 pandemic, including use of video and audio-only modalities, virtual establishment of new patients, and payment parity with in-person visits.

Quality Improvement

- Improve alignment between state and federal regulators and the National Committee for Quality Assurance (NCQA), including quality metrics, data collection, network adequacy and value-based programs.
- Incorporate dual-eligible status into risk adjustment, Star Ratings and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
- Allow more flexible distance standards for specialty care providers.
- Improve CAHPS survey to account for delegated delivery model and new forms of health care services, including CS and telehealth utilization.

Social Determinants of Health (SDOH)

- Support policies, funding and flexibility to address SDOH, such as housing, transportation and food insecurity.
- Support the construction and permitting of supportive housing and recuperative care facilities.
- Remove barriers to Medi-Cal enrollment, services and access to care for individuals experiencing homelessness.
- Improve collection and sharing of SDOH and demographic data across public agencies, health plans, utility providers and community-based organizations.

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Approve Actions Related to CalOptima Health's Medi-Cal and the Program of All-Inclusive Care for the Elderly Disposable Incontinence Supplies Vendor Contracts

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Authorize the Chief Executive Officer to renew contracts with current Medi-Cal and the Program of All-Inclusive Care for the Elderly (PACE) disposable incontinence supplies (DIS) vendors through a standard network provider contracting process, effective January 1, 2024; and
2. Authorize the Chief Executive Officer to contract with all willing and qualified DIS vendors under the same contract terms and conditions starting January 1, 2024.

Background and Discussion

DIS are covered under CalOptima Health's Medi-Cal and PACE programs. CalOptima Health utilizes the ancillary services contract for these supply vendors. Under current contract terms, DIS vendor contracts are set to expire on December 31, 2023, with no additional contract extensions remaining. DIS vendor contracts will need to be re-established beginning January 1, 2024. CalOptima Health has two options for executing the new ancillary services agreements for DIS; repeat the RFP process that was conducted previously, or establish the agreements through CalOptima Health's standard network provider contracting process and open the network to any willing and qualified provider.

A standard network contracting process would allow for the expansion of CalOptima Health's provider network rather than limit it to the number of vendors selected through an RFP.

As such, staff request Board approval of the following:

1. Execute 2024 ancillary services agreements with current DIS vendors through CalOptima's standard network provider contracting process, effective January 1, 2024; and
2. Contract with all willing and qualified DIS vendors under the same contract terms and conditions starting January 1, 2024.

Fiscal Impact

Assuming utilization levels will remain the same, there is no additional fiscal impact associated with the recommended actions. Management will include medical expenses related to DIS for the period beginning January 1, 2024, and after in the CalOptima Health Fiscal Year 2023-24 and future operating budgets.

Rationale for Recommendation

Approving the transition of ancillary services contracts for DIS vendors to the standard network provider contracting process would ensure a robust network of providers and be consistent with other contracting efforts.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Ancillary Services Contract

Board Actions
N/A

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Byram Healthcare Centers Inc.	5302 Rancho Road	Huntington Beach	CA	92647
Caremax RM Corporation	8271 Commonwealth Ave.	Buena Park	CA	90621
Schraders Medical Supply Inc.	5507 Brooks St.	Montclair	CA	91763
Shield-California Health Care Center	27911 Franklin Pkwy.,	Valencia	CA	91355

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ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("CalOptima"), and **[Test Provider - CalOptima Use Only]** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

F. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract:

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.3 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 – 41518.9.

1.4 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.5 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.5.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

1.5.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.6 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.7 "CalOptima Programs" means the Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.8 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.9 "CCS Providers" or "CCS-Paneled Providers(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

1.10 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.11 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.12 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.13 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.14 “Coordination of Benefits” or “COB” refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.15 “Covered Services” means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the DHCS Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.16 “Effective Date” means the effective date of commencement of the Contract as provided in Article 10.

1.17 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.18 “Government Agencies” means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

1.19 “Government Contract(s)” means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.20 “Government Guidance” means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.21 “Health Network” means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.22 “Licenses” means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.23 “Medi-Cal” is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.24 “Medically Necessary” or “Medical Necessity” means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

1.25 “Medicare” means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.26 “Medicare Secondary Payer” or “MSP” means the Medicare coordination of benefits requirements as incorporated in MA regulations.

1.27 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.28 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.29 "Participating Provider" means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.30 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.31 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.32 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.
PACE Services shall include the following:

a. All Medicare-covered items and services

b. All Medi-Cal covered items and services; and

c. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1.33 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.34 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

1.35 Whole Child Model Program" or "WCM", means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.22 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or participation status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to Health Networks the same terms regarding Provider performance, duties and obligation and rates for Covered Services provided to CalOptima Members enrolled in Health Networks. Provider agrees to contract with a Health Network(s) upon the request of a Health Network(s).

2.12 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to

Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638.

2.13 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.14 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.15 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

2.16 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

2.17 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and

medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.18 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.19 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.20 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.21 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and

Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.22 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.23 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.24 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall

make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.24.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.24.2 An agreement to maintain such books and records (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.24.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.24.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients.

2.24.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.24.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

2.24.7 An agreement to comply with CalOptima's Compliance Program.

2.24.8 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.25 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.26 Participation Status. Provider shall have Policies and Procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.26.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.26.2 Provider shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.26.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.26.4 Provider shall include the obligations of this Section in its Subcontracts.

2.26.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.27 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

2.28 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access

for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.29 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.30 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.31 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.32 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.33 Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.34 Whole Child Model Program Compliance. If Provider is a CCS authorized provider, then in the provision of CCS Services to CalOptima Members, the Provider shall follow CCS Program Guidelines, including CCS Program regulations, and where CCS Clinical guidelines do not exist, Provider will use evidence -based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.35 CCS Provider Compliance.

2.35.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.35.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.35.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.35.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.36 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.37 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.38 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

3.3 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

ARTICLE 4
PAYMENT PROCEDURES

4.1 Billing and Claims Submission. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and

that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 COB. Provider shall coordinate benefits with other programs or entitlements recognizing where OHC is primary coverage in accordance with CalOptima Program requirements. Provider acknowledges that Medi-Cal is the payor of last resort.

4.6 (This section left intentionally blank)

4.7 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.7.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

4.7.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.7.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.7.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.8 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.8.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

4.8.3 Unpaid Conlan reimbursements owed by provider to a Member.

4.8.4 Payments made for services provided by a Provider that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract,

Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure

that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days' prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.9 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

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

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the

parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

{{*Name on Notice_es_:signer1: }}

Name

{{*Title on Notice_es_:signer1: }}

Title

{{*Address on Notice_es_:signer1 }}

Address

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Provider covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Dispute Resolution.

9.15.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either

party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.15.2.

9.15.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.15.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.15.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

9.15.4 Waiver. By agreeing to binding arbitration as set forth in Section 9.15.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

X Medi-Cal Program

X Medicare Advantage Program (OneCare)

X PACE Program

ARTICLE 2
SERVICES

2.1 Scope of Covered Services. "Covered Services" as referred to in this Contract means those items and services as defined under applicable CalOptima Programs and CalOptima Policies and required to be furnished under this Contract, and provided to Members who are authorized to receive such items and services including:

@@Custom Field{Ancillary Scope of Covered Service}@@

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS AND PACE PARTICIPANTS

1.1 CalOptima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) and PACE with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD and PACE Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

2.1 Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C
COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Medi-Cal Program Reimbursement

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges or

   1.1 [redacted] of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis, as defined in CalOptima Policies.

   1.2 [redacted] of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis, as defined in the Provider Manual for **Child Health and Disability Prevention (CHDP)** services provided by a Physician**. This also applies to CalOptima members assigned to Health Networks when CalOptima is responsible for CHDP payment.**

2. Services with Unestablished Fees. If a fee has no been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at [redacted] of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

4. Professional shall utilize current payment codes and modifiers for Medi-Cal.

5. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

6. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

II. Medicare Advantage (OneCare) Program Reimbursement

For Medicare Advantage (OneCare) Members, CalOptima shall reimburse for Covered Services as follows:

1. Billed charges or

   1.1 [redacted] of the current year CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Provider to provide such service, CalOptima shall reimburse Provider under the following guidelines:

4.1 "By Report & Unlisted" codes will be paid at [redacted] of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided.

4.2 Provider shall utilize current payment codes and modifiers for Medicare.

4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

4.4 Should Medicare consider a service as non-covered, and services are covered by Medi-Cal, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification and these will be handled on a case-by-case basis.

4.6 Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

III. PACE Program Reimbursement

For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges or

   1.1 [redacted] of the Current CalOptima Medicare Fee Schedule on a fee-for-service basis, as defined in CalOptima Policies.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payments Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at [redacted] of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided.

   4.2 Provider shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 Should Medicare consider a service as non-covered, and services are covered by Medi-Cal, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification and these will be handled on a case-by-case basis.

4.6 Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

IV. Cal MediConnect (OneCare Connect) Program Reimbursement

For Covered Services provided to Cal MediConnect Members (OneCare Connect) Members, CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of:

- Not Applicable

ATTACHMENT D

DISCLOSURE FORM

[Test Provider - CalOptima Use Only]
Name of Provider

The undersigned hereby certifies that the following information regarding **[Test Provider - CalOptima Use Only]** (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

{{*Owner1_es_:signer1	}}
{{Owner2_es_:signer1	}}
{{Owner3_es_:signer1	}}
{{Owner4_es_:signer1	}}

Co-Owner(s):

{{*Co-Owner1_es_:signer1	}}
{{Co-Owner2_es_:signer1	}}
{{Co-Owner3_es_:signer1	}}
{{Co-Owner4_es_:signer1	}}

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

{{*Ownership(%)1_es_:signer1	}}
{{Ownership(%)2_es_:signer1	}}
{{Ownership(%)3_es_:signer1	}}
{{Ownership(%)4_es_:signer1	}}

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

{{*Creditor(%)1_es_:signer1	}}
{{Creditor(%)2_es_:signer1	}}
{{Creditor(%)3_es_:signer1	}}
{{Creditor(%)4_es_:signer1	}}

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

{{*Company Type1_es_:signer1	}}
{{Company Type2_es_:signer1	}}
{{Company Type3_es_:signer1	}}
{{Company Type4_es_:signer1	}}

Date: {{_es_:signer1:date }}

Signature: {{_es_:signer1:signature }}

Name: {{Name_es_:signer1: }}
(Please type or print)

Title: {{_es_:signer1:title }}
(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Provider shall maintain and retain all records of all items and services provided to Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of Contract, available for purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at the Provider's place of business or such other mutually agreeable location in California, and (c) in a form maintained in accordance with general standards applicable to such book or record keeping, for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Provider shall cooperate in the audit process by signing any consent forms or documents required by but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise

3. Form of Records. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Part Tort Liability/Estate Recovery. [State Contract, Ex. E, Att 2 § 22] Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation. [State Contract, Ex. A, Att. 6, § 12(B)(15), Ex. E, Att. 2, § 23]

5.1. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

5.2. In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1. CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2. If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1. Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2. Costs for copies of all documentation submitted to CalOptima pursuant to paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3. Provider shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Provider under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. [State Contract, Ex. A, Att. 4, § 13] All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider site.

7. Downstream Contracts. [State Contract, Ex. A, Att. 6, § 12(B)(9)] In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS.

8. (This section left intentionally blank).

9. Changes in Availability or Location of Services. [State Contract, Ex. A, Att. 9, § 9] Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

10. Confidentiality of Medi-Cal Members. [State Contract, Ex. D(F) § 13; Ex. E, Att. 2, § 19] Provider and its employees, or agents shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, or agents as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, or agents shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, or agents shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable

law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider, Provider:

10.1. will not use any such information for any purpose other than carrying out the express terms of this Contract,

10.2. will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

10.3. will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

10.4. will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

11. Debarment Certification. [State Contract, Ex. D(F), § 19] By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

11.1. By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

11.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

11.1.2. Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

11.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 11.1.2 herein; and

11.1.4. Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

11.1.5. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

11.1.6. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

11.2. If the Provider is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to CalOptima.

11.3. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

11.4. If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

12. DHCS Directions. [State Contract, Ex. E, Att. 2, § 15] If required by DHCS, Provider shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. [State Contract, Ex. D(F), § 11] Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14. Lobbying Restrictions and Disclosure Certification. [State Contract, Ex. D(F), § 31]

14.1. (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.2. Certification and Disclosure Requirements

14.2.1. Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 14.3 of this provision.

14.2.2. Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

14.2.3. Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

14.2.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.2.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.2.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.2.4. Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.3. Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15. Additional Subcontracting Requirements. [State Contract, Ex. A, §12(B)(11)]

15.1. Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

15.1.1. Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2. Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

15.2. Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1. Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2. Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

15.2.3. An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

15.2.4. An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.5. An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.36 and 6.6 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 and 22 of this Addendum 1.

15.2.6. An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.7. An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.8. An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 17 of this Addendum 1.

15.2.9. An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.10. An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.6 of the Contract.

15.2.11. An agreement to notify DHCS in the manner provided in Section 7.11 of the Contract in the event the Subcontract is amended or terminated.

15.2.12. An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.29 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section

1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.28 or the Contract.

15.2.13. Subcontractor shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal members, as provided in CalOptima Policies relative to the Medi-Cal Program, and excluding any contract disputes between Provider and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

15.2.14. An agreement to participate and cooperate in quality improvement system as set forth in Section 2.25 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

15.2.15. If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.16. An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.7. of the Contract.

15.2.17. An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.18. An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

16. State's Right to Monitor. Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

17. Provider shall comply with all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

18. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

21. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

23. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

26. Provider shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by the Provider pursuant to the Contract.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima OneCare Program (OneCare):

1. Record Retention. Provider and it Subcontractors agree to retain books, records, contracts, computer or other electronic systems information, medical records, and documents related to this Contract and/or CMS Contract for at least ten (10) years from the final date of the CMS Contract period, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Provider and its Subcontractors agree:

   2.1 To maintain and make available contracts, books, computer or other electronic systems, medical records, documents, and records related to this Contract and/or CMS Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory agency or accrediting organizations or their designees to inspect, evaluate, collect, and audit for ten (10) years from the final date of the CMS Contract period or from the date of completion of any audit, whichever is later.

   2.2 For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to in Section 2.1 of this Addendum 2, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

   2.3 For records subject to review under Section 2.1 of this Addendum 2 by HHS, the Comptroller General, or their designees, CMS will, except in exceptional circumstances, provide notification to CalOptima that a direct request for information has been initiated.

3. Accountability Acknowledgement. Provider further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Provider pursuant to the Contract relative to the OneCare Program are consistent and comply with CalOptima's contractual obligations under the CMS Contract and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Provider under this Contract, Provider warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Provider agrees to perform the delegated activities in a manner consistent with the delegation criteria. Provider agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Provider acknowledges that delegation to another entity does not alter Provider's ultimate obligations and responsibilities set forth in this Contract. Provider acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

(b) Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

(c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Provider, which will be monitored by CalOptima on an ongoing basis. In the event Provider breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Provider as set forth in this Contract. Moreover, CalOptima shall have the right to require Provider to terminate any Subcontracting Provider for good cause, including but not limited to breach of its obligations to perform any delegated duties.

(d) Review of Credentials. Provider shall ensure that the credentials of medical Providers affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review and approve Provider's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Provider agrees to comply with MSP requirements. Provider shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Provider will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Provider Authority to Bill Third Party Payers. Provider may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Provider Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Provider may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Provider shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Provider agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Provider bills a third party payor as primary. Provider agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Provider within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Provider, or, CalOptima will contest or deny Provider's claim within forty-five (45) business days following CalOptima's receipt thereof.

7. In addition to Section 2.26 of this Contract, Provider and its Subcontractors shall ensure that payments are not made to individuals or entities included on the Preclusion List.

8. Additional Subcontractor Requirements. If any Covered Services relative to the OneCare Program under this Contract are to be provided by a Subcontractor on behalf of Provider, Provider shall ensure that such subcontracts are in writing and include the following:

    8.1 An agreement to comply with the HHS and the Comptroller General, or their designees' right to directly audit, evaluate, collect, and inspect Subcontractors books, contracts, computer or other electronic systems, including medical records and documentation related to CMS' OneCare contract with CalOptima, for any particular contract period for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

    8.2 For records subject to review under Section 8.1 of this Addendum 2, except in exceptional circumstances, CMS will provide notification to CalOptima that a direct request for information has been initiated.

    8.3 An agreement to Member financial protections in accordance with Section 4.6 of the Contract, including prohibiting Subcontractors from holding a Member liable for payment of any fees that are the legal obligation of Provider.

    8.4 An agreement to provide for continuation of health care benefits for the duration of the contract period for which CMS payments have been made; and for Members who are hospitalized on the date its contract with Provider terminates, or, in the event of Provider's insolvency, through the date of discharge.

    8.5 An agreement that CalOptima may only delegate activities or functions to a Subcontractor in a manner consistent with requirements set forth in Section 8.7 of this Addendum 2.

    8.6 An agreement to ensure that delegated activities or functions are consistent with CalOptima's OneCare contract requirements set forth by CMS.

    8.7 If any of CalOptima's activities or responsibilities under this Contract are delegated to a Subcontractor, the following requirements apply and such subcontract must specify:

        8.7.1 the delegated activities and reporting responsibilities.

        8.7.2 either a provision for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or CalOptima determine that such parties have not performed satisfactorily.

        8.7.3 that performance of the parties is monitored by CalOptima on an ongoing basis.

        8.7.4 that the credentials of medical Providers affiliated with Subcontractor will be either reviewed by CalOptima; or the credentialing process will be reviewed and approved by CalOptima, and CalOptima must audit the credentialing process on an ongoing basis.

        8.7.5 an agreement to comply with all applicable Medicare laws, regulations and CMS instructions.

    8.8 If CalOptima delegates selection of Providers, contractors, or subcontractors to Provider or Subcontractor, CalOptima retains the right to approve, suspend, or terminate such arrangement

ADDENDUM 3
CAL MEDICONNECT PROGRAM REQUIREMENTS

Not Applicable to this Contract

ADDENDUM 4
PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 4 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

1.1. This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

1.2. Amendments to this Contract and amendments to any subcontract agreements between Provider and subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

1.3. CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees.
Provider shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE enrollees, Provider agrees to do the following:

2.1. Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

2.2. Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

2.3. Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

2.4. Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5. Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and

Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

2.6. Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

2.7. Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8. Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9. Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10. Provision of Direct Care Services to PACE Participants. Provider hereby represents and warrants that Provider and all employees of Provider providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Provider agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Provider or any employee of Provider providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.10.1. Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2.10.2. Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Provider furnishes;

2.10.3. Have verified current certifications or licenses for their respective positions;

2.10.4. Have not been excluded from participation in Medicare, Medicaid or Medi-Cal;

2.10.5. Have not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2.10.6. Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2.10.7. Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2.10.8. Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.11. The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the

proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

12.1.1. will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2. will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3. will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4. will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

13. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

13.1. By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

13.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

13.1.2. Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

13.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 13.1.2 herein; and

13.1.4. Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

13.1.5. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

13.1.6. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

13.2. If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

13.3. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

13.4. If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

15. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

16. Lobbying Restrictions and Disclosure Certification.

16.1. (Applicable to federally funded contracts in excess of $100,000, per Section 1352 of the 31, U.S.C.)

16.2. Certification and Disclosure Requirements

16.2.1. Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 16.3 of this provision.

16.2.2. Each recipient shall file a disclosure (in the form set forth in Attachment 2 to Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 16.3 of this provision if paid for with appropriated funds.

16.2.3. Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure, or that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

16.2.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

16.2.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

16.2.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

16.2.4. Each person (or recipient) who requests or receives from a person referred to in Paragraph 16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

16.2.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

16.3. Prohibition—Section 1352 of Title 31, U.S.C., provides, in part, that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

17. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

Addendums - Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than #100,000 for each failure.

[Test Provider - CalOptima Use Only]	{{N_es_:signer1:fullname }}
Name of Contractor	Printed Name of Person Signing for Contractor
	{{_es_:signer1:signature}}
Contract / Grant Number	Signature of Person Signing for Contractor
{{_es_:signer1:date }}	{{_es_:signer1:title }}
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendums--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: {{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	2. Status of Federal Action: {{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	3. Report Type: initial {{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity: {{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: {{RepEntNmSub_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDistSub_es_signer1 }}
6. Federal Department/Agency: {{FedDeptAgen_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA_es_signer1 }}
8. Federal Action Number, if known: {{FedDeptNo_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s))	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature Value {{Value_es_:signer1 }}	13. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}} Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ironwood Health LLC to Provide Professional Services for the Implementation of the New Clinical Care Management System.

Contacts

Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Authorize the Chief Executive Officer to execute a contract amendment with Ironwood Health LLC (Ironwood Health) to provide consultation and support to implement CalOptima Health's new care management system.
2. Authorize unbudgeted expenditures and appropriate funds in an amount of up to $500,000 from the Digital Transformation and Workplace Modernization Reserve to fund the expansion of the Ironwood Health services to provide industry expertise on the care management system implementation through October 31, 2023.

Background

As part of the CalOptima Health's Digital Transformation Strategy, on May 3, 2022, staff entered into a contract with ZeOmega, Inc. (ZeOmega) for a clinical documentation system that will replace CalOptima Health's current clinical system. ZeOmega's clinical care management system will serve as an electronic health record to coordinate clinical program activities, including treatment authorization requests and supporting clinicals, integrated appeals, grievances and quality modules to support members and direct care providers. The new care management system's capabilities allow for access to new and emerging automation, technology, and protocols to enhance the accuracy, timeliness and experience of members, providers, and staff. During the initial phase of the care management system implementation, staff identified the need for consultative services to assess the business architecture, operational readiness, and transformational use of the new system. Staff entered into a contract with Ironwood Health in the amount of $250,000 awarded through the informal bid process and stated that any funds above $250,000 were outside the bid thresholds. Ironwood Health was selected based on extensive specialization in large scale transformation and implementation of managed care clinical care management platforms.

Discussion

Ironwood Health completed its contracted deliverables, which included:

- Assessing current clinical processes, business architecture, and program governance;
- Developing the current end-to-end value chain mapping of departmental clinical processes and identifying several inefficiencies such as use of disparate systems and processes with recommendations for improvement;

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- Developing the current member experience journey through the clinical program and identifying many "pain points", such as unnecessary hand-offs between case managers, repeatable questions asked to the member about their health, and the lack of a holistic view of the member care programs;
- Documenting gaps between system integration and recommending how streamlining data flow will ensure the member is placed in the appropriate care program systematically;
- Evaluating the project governance and organizational structure and recommending a new program governance structure for implementation to ensure a more transparent decision-making process at the executive level.

Based on the result of Ironwood Health's assessment and recommendations, staff is focusing on the following key areas of opportunity and solutions for a successful launch of the new care management system:

- Realignment of the clinical areas to leverage system capabilities and increase the clinical teams' competencies agnostic of current department or reporting structure;
- Care model redesign that puts the member's experience first and allows clinical and operational teams to leverage industry best practices, economies of scale, and continue to meet regulatory requirements;
- Use of technology platforms that drive interoperability between internal and external systems such as hospitals, community-based organizations, and health networks.

Staff recommends the continued services and expertise of Ironwood Health to assist in the successful delivery of the new care management system. Ironwood Health will focus on the following deliverables:

- Designing and building a future state business architecture and set of process flows ensuring the clinical operations is using the new system as their primary vehicle in providing care to members;
- Developing a practical set of clinical guidelines to be used when managing a member care program along with a set of rules to generate the appropriate care assessments based on the member's health needs;
- Developing an inventory of information and data used to inform the member's health risk level and appropriate program;
- Defining and implementing a program organizational structure and instilling a disciplined approach to ongoing project execution; and
- Developing an operational readiness plan, which includes operational change management and training, readiness criteria, and decision-making governance processes beyond the implementation of the new system.

Fiscal Impact

The recommended action is unbudgeted **in** Fiscal **Year 2022-23**. **A previous Board action on March 17, 2022, established a restricted Digital Transformation and Workplace Modernization** Reserve (DTS reserve) in the amount of $100 million. An appropriation of up to $500,000 from the balance of

the DTS reserve will fund the contract amendment with Ironwood Health for services through **Octo**ber 31, 2023.

Rationale for Recommendation

Ironwood Health's expertise, in partnership with CalOptima Health, will ensure the new clinical platform and organizational use of such a system is optimized for the future and the benefit of CalOptima Health's providers and members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

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Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
May 5, 2022	Authorize the Chief Executive Officer to Negotiate, Execute and Implement ZeOmega, Inc. Contract for a Care Management System in Support of CalOptima's Digital Transformation Strategy	Five years, with three one-year extension options.	$11.4 million

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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Attachment to the April 6, 2023 Board of Directors Meeting – Agenda 15

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Medical Group	Address	City	State	Zip Code
ZeOmega		6200 Tennyson Parkway Suite 200	Plano	Texas	75024
Ironwood Health LLC		3308 E. Camino Boscaje Escondido	Tuscon	Arizona	85718

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ankura Consulting Group, LLC to Provide Professional Services for Credentialing Process Review and Proposed Budget Allocation Changes in the CalOptima Health Fiscal Year 2022-23 Operating Budget.

Contacts

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Authorize the Chief Executive Officer to execute a contract amendment with Ankura Consulting Group (Ankura) to consult and conduct credentialing process review; and
2. Authorize reallocation of budgeted but unused funds in the amount of $200,000 from Medi-Cal: Professional Fees in Audit & Oversight to Medi-Cal: Professional Fees in the Office of Compliance to fund the contract amendment through June 30, 2023.

Background

As part of CalOptima Health's ongoing preparation and readiness for regulatory audits, staff selected and contracted with Ankura through an RFP process released on May 18, 2022. The Ankura contract is effective from October 18, 2022, through July 31, 2024. During the audit readiness process with Ankura, staff realized that there is a need for consultative services to review CalOptima Health's end-to-end credentialing process.

Discussion

Ankura provided consulting services to CalOptima Health to prepare for its annual Department of Health Care Services (DHCS) medical audit. During this readiness process, staff identified the need for additional services to review the credentialing process, including policies, procedures, and workflows.

The provider credentialing process has operational linkages to provider contracting, utilization management, and claims. Ankura is uniquely positioned to provide credentialing consulting services to CalOptima Health given its deep knowledge of CalOptima Health's policies, processes, workflows, and staffing model that Ankura evaluated as part of its DHCS audit readiness services.

Staff recommends amending the Ankura contract scope of work to expand services to include consulting and review of CalOptima Health's credentialing process. Under the credentialing scope of work, Ankura will perform end-to-end provider credentialing process walk-throughs and assessments, credentialing file review, and credentialing system review. This work will include reviewing the entire credentialing process from intake, triage, primary source verifications, communication and information requests, provider file setup and system loading, and validation of proper file execution. This scope of work is

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expected to occur over 12 weeks, starting April 17, 2023. All other contract terms and conditions will remain the same.

Staff recommends reallocation of $200,000 in budgeted but unused funds from the FY 2022-23 Medi-Cal: Professional Fees in Audit & Oversight. The expansion of the scope of work and the resulting increase in total expenses exceeds the informal bid threshold allowed under CalOptima Health Policy GA.5002: Purchasing and requires separate Board action. These budgeted funds under the Audit and Oversight department are available for reallocation due to a portion of the Ankura audit scope of work being handled by internal staff and a delay in contracting with an external resource until next fiscal year.

Fiscal Impact

The recommended action is budget neutral. Unspent budgeted funds in the amount of $200,000 from Medi-Cal: Professional Fees in Audit & Oversight approved in the FY 2022-23 Operating Budget will fund the contract amendment through June 30, 2023. Management will include expenses related to the proposed contract extension in future operating budgets.

Rationale for Recommendation

Ankura's expertise, in partnership with CalOptima Health, will ensure compliant and operationally efficient credentialing processes.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Ankura Consulting Group, LLC	485 Lexington Ave., 10th Floor	New York	NY	10017

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Approve New CalOptima Health Policy MA.2017p: Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Javier Sanchez, Executive Director, Medicare Programs, (657) 235-6851

Recommended Action

Approve CalOptima Health Policy MA.2017p: Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents.

Background

Staff requests approval of new CalOptima Health Policy MA.2017p: Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents. This policy is a new policy being presented for consideration by CalOptima Health Board of Directors (Board). CalOptima Health has contracted with three field marketing organizations (FMO) facilitating enrollment of dual-eligible members into CalOptima Health's OneCare (HMO D-SNP) program as of January 1, 2023. CalOptima Health is required to comply with Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) guidance and regulations for conducting training, audit, and oversight of FMOs and their subcontracted independent insurance agents that enroll members in CalOptima Health's OneCare plan. To that end, staff created Policy MA.2017p to outline procedures for conducting training, audit, and oversight of the contracted FMOs and their agents in alignment with DHCS and CMS regulations and requirements.

Discussion

CalOptima Heath must oversee the FMOs and their independent agents to ensure they abide by all applicable state and federal laws, regulations, and requirements, including Title 42, Code of Federal Regulations, Parts 422 Subpart V, 423 and 417, the DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide, and the Medicare Managed Care Manual, Chapter 2 ("Medicare Advantage Enrollment and Disenrollment"), and Chapter 3 ("Medicare Communications and Marketing Guidelines"). In accordance with these regulations, MA.2017 requires that CalOptima ensure all FMOs and broker agencies comply with the following, effective January 1, 2023:

1. Ensure all independent agents complete training and testing required to maintain and renew a valid insurance license from the California Department of Insurance (DOI) prior to conducting enrollment sessions.

2. Ensure independent agents complete CalOptima Health's training program, testing, and certification prior to enrolling members in OneCare.

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3. Ensure additional training is provided as necessary to reinforce marketing practices as required by the Code of Federal Regulations, Medicare Communication and Marketing Guidelines (MCMG), and DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide.

4. Ensure all independent agents pass the annual American Health Insurance Plan (AHIP) training and testing and obtain Medicare certification.

5. Follow the established audit and oversight process for each independent agent.

6. Ensure independent agents use the CMS-approved member enrollment kit.

7. Conduct quality control of OneCare enrollments completed by independent agents.

8. Ensure independent agents adhere to requirements for providing appropriate disclaimers and recording marketing and sales calls in accordance with CMS calendar year 2023 agent broker training and testing requirements.

9. Monitor recorded sales and marketing calls.

10. Investigate and respond to CalOptima Health staff regarding issues related to sales calls.

MA.2017 will undergo annual review by internal staff and updated as necessary to ensure it reflects the latest applicable state and federal reporting requirements. To ensure FMOs and independent agents are aware of procedural requirements for enrolling CalOptima Health's OneCare members, and ensure appropriate audit, oversight, and monitoring on behalf of CalOptima Health, staff requests the Board approve MA.2017p: Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in CalOptima Health's Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

Policy MA.2017p: Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents will ensure CalOptima Health and FMOs and their independent agents are apprised of required reporting requirements and guide staff in conducting necessary audit, monitoring, and oversight of applicable contract, policy, and regulatory requirements.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action
2. Policy MA.2017: *Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents (Watermarked Final Policy))*, which includes:
   - Third-Party Marketing Organization (TPMO) Disclaimer
3. Title 42, Code of Federal Regulations, Parts 422 Subpart V, 423 and 417
4. DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide
5. Medicare Manual Chapter 3 - Medicare Communications and Marketing Guidelines (MCMG)
6. Medicare Manual Chapter 2 – Medicare Advantage Enrollment and Disenrollment

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Applied General Agency (AGA)	1040 N Tustin Ave.	Anaheim	CA	92807
iPros Insurance Professionals	101 N. Orange Ave. Ste. D	West Covina	CA	91790
JAR Insurance Services	17215 Studebaker Rd. Ste. 390	Cerritos	CA	90703

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Policy:	MA.2017p
Title:	**Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents**
Department:	Network Operations
Section:	OneCare Sales & Marketing
CEO Approval:	*/s/*
Effective Date:	01/01/2023
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the training and oversight of Field Marketing Organization (FMO) or Broker Agency and their subcontracted independent agents in compliance with the Title 42, Code of Federal Regulations (CFR) Part 422 and 423, Subpart V, Centers for Medicare & Medicaid Services (CMS) Medicare Communications and Marketing Guidelines (MCMG), Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide and CalOptima Health Marketing policies.

II. POLICY

A. FMO or Broker Agency is responsible to verify if agent(s) have an active license including all educational requirements.

B. CalOptima Health and Field Marketing Organization (FMO) or Broker Agency shall ensure that all independent agents complete a thorough training program prior to conducting an enrollment session.

C. FMO or Broker Agency will monitor independent agents through a variety of mechanisms on an ongoing basis to ensure continuous compliance with all State and Federal requirements as they pertain to sales and marketing activities. FMO or Broker Agency should conduct monthly sales-events audits, coaching and feedback should be provided to their agent(s).

D. CalOptima Health OneCare Sales and Marketing shall provide FMO or Broker Agency, training program and testing for product/benefit, enrollment process and regulations updates. Independent agents must complete training to be certified and ready-to-sell (RTS) and be allowed to enroll in OneCare. Training and testing must take place prior to enrolling members into OneCare (HMO D-SNP) and renewed annually before October 01, or upon executing subcontract with FMO.

E. FMO or Broker Agency shall review CFR, MCMG, DHCS DSNP Plan Policy Guide and CalOptima Health Training and Oversight of independent agents to ensure independent agents and other marketing staff remain informed and compliant with the latest applicable marketing rules and regulations as set forth by CMS, DHCS and DHMC.

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F. FMO or Broker Agency will ensure that independent agents complete CMS required annual training and testing on Medicare rules and regulations and obtain a Medicare Fraud, Waste, and Abuse Training Certification. Training and testing must take place prior to enrolling members into OneCare and renewed annually before October 01 or upon executing subcontract with FMO.

G. FMO or Broker Agency will retain evidence and ensure that each of their subcontracted independent agents have an annual AHIP Medicare Certificate, a valid and active California Department of Insurance (DOI) license to transact Medicare enrollments, and an Error and Omissions (E&O) Certificate.

H. FMO or Broker Agency will provide CalOptima Health copies of AHIP Medicare Certificate, California DOI Insurance License, and E&O Certificate.

I. FMO or Broker Agency must ensure to use OneCare marketing materials and enrollment packet (kit) that CalOptima Health develops and provides to FMO.

J. FMO or Broker Agency must distribute OneCare Enrollment kits and ensure that independent agents use during enrollment appointments.

K. FMO or Broker Agency must provide interpreter services during OneCare Enrollment appointments.

L. FMO or Broker Agency must report sales/marketing events and must be reported to CalOptima Health's RAC Medicare twenty-one (21) days prior to event.

M. FMO or Broker Agency or subcontracted independent agents are not allowed to use CalOptima Health name, logo or other proprietary mark in any press release, advertising, promotional, marketing, or similar publicly disseminated material without first submitting such material to CalOptima Health and obtaining written approval of the material and consent to such use.

N. FMO or Broker Agency shall meet with CalOptima Health OneCare Sales and Marketing monthly or more often if required to review all sales and marketing activities, production, rapid disenrollment, complaints, sales allegations and/or grievances, report if any subcontracted agent has lost credentials to be allowed to enroll in Medicare, and update on provider and member outreach activities.

III. PROCEDURE

A. FMO or Broker Agency shall ensure that all independent agents complete a comprehensive training program prior to conducting an enrollment session.

1. Upon execution of subcontract with FMO or Broker Agency each independent agent shall participate in a training program that includes review of the following:

   a. Code of Federal (CFR) Regulations, Title 42 – Public Health, Part 422 - Medicare Advantage Program, Subpart V- Medicare Advantage Communication Requirements.

   b. CMS Medicare Manual Chapter 3 - Medicare Communication and Marketing Guidelines (MCMGs).

   c. DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide.

d. CMS Medicare Manual Chapter 2 - Medicare Advantage Enrollment and Disenrollment Guidance.

e. CMS-approved OneCare Marketing materials.

f. CMS-approved Summary of Benefits for OneCare Program; and

g. CMS-approved OneCare Evidence of Coverage/Member Handbook.

2. FMO or Broker Agency shall ensure that each independent agent completes CalOptima Health's training program and testing for product/benefit, enrollment process and regulations updates. Independent agents must complete training to be certified and ready-to-sell (RTS) and be allowed to enroll in OneCare. Training and testing must take place prior to enrolling members into OneCare and renewed annually before October 01 or upon executing subcontract with FMO.

3. FMO or Broker Agency shall provide additional training, as necessary, to reinforce specific marketing practices and as a result of any updates to the Code of Federal Regulations, Medicare Communications and Marketing Guidelines (MCMG), and DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide. FMO or Broker Agency shall document and retain trainings with agendas, sign-in sheets, and training handouts or attestations if applicable.

B. Oversight and Monitoring of Independent Agents

1. FMO or Broker Agency will ensure that each independent agent completes annual American Health Insurance Plan (AHIP) training and testing with a passing score or better. FMO or Broker Agency will retain a copy of Certificate of completion.

2. FMO or Broker Agency shall follow established audit and oversight process for each independent agent and report to CalOptima Health any deficiencies, corrective actions and/or termination of subcontract with specific independent agent.

3. FMO or Broker Agency will ensure that independent agents use CMS approved enrollment kit that includes:

a. OneCare Pre-Enrollment Check List (PECL);

b. Notice of Non-Discrimination (NOND);

c. OneCare Multi-Language Insert (MLI);

d. OneCare Star Rating Letter;

e. Third-Party Marketing Organization (TPMO) Disclaimer Insert;

f. OneCare Summary of Benefits (Booklet);

g. OneCare Scope of Appointment (SOA); and

h. OneCare Enrollment Form.

4. FMO or Broker Agency shall conduct quality control of each OneCare enrollment that their independent agents submit to ensure content, dates and signatures meet CMS requirements. FMO or Broker Agency must abide by Medicare Record retention requirements of ten (10) years.

5. FMO or Broker Agency as a downstream entity must ensure that the subcontracted independent agents convey:

   a. "Third-Party Marketing Organization (TPMO) Disclaimer" within the first minute of a recorded sales call, and prominently displayed on TPMO websites, and included in marketing materials, print and TV ads. The disclaimer statement consists of, "We do not offer every plan available in your area (Orange County, California). Any information we provide is limited to those plans we do offer in your area (Orange County, California). Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

   b. Agents must record all individual marketing/sales calls, in accordance with CMS CY 2023 Agent Broker training and testing requirements (Reissued 07/06/2022). Recorded calls must be available, downloadable for random audits from CalOptima Health or regulators. FMO or Broker Agency must abide by Medicare Record retention requirements of 10 years.

6. As necessary, FMO or Broker Agency shall monitor recorded sales and marketing calls to ensure compliance with CFR, MCMG, and DHCS CalAIM DSNP Plan Policy Guide.

7. FMO or Broker Agency shall review and investigate any grievances filed against independent agents.

8. FMO or Broker Agency will investigate and respond to CalOptima Health staff regarding member's complaint, sales allegation and/or grievance against independent agent(s) within required timeframe, addressing member's allegations and indicating if any action was taken to prevent future occurrences, if appropriate.

IV. ATTACHMENT(S)

A. Third-Party Marketing Organization (TPMO) Disclaimer

V. REFERENCE(S)

A. Agent and Broker Training & Testing Minimum Requirements, Reissued 07/06/2022
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy MA.2001: Marketing Material Standards
D. CalOptima Health Policy MA.2002: Marketing Activity Standards
E. Contract Year 2023 Agent/Broker Compensation Rate Adjustments and Submissions & Agent/Broker Training and Testing Requirements, Reissued 07/06/2022
F. Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide, Issued August 2022
G. Medicare Managed Care Manual, Chapter 2, Medicare Advantage Enrollment and Disenrollment, Issued 08/12/2020
H. Medicare Managed Care Manual, Chapter 3, Medicare Communications and Marketing Guidelines (MCMG) (CMS memorandum updates to contract year (CY) 2019 MCMG), Issued 02/09/2022
I. Title 42, Code of Federal Regulations (C.F.R.), Parts 422 Subpart V, 423 and 417, Amended 10/03/2022

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	MA.2017p	Training and Oversight of Field Marketing Organization/Broker Agency and Subcontracted Independent Agents	OneCare

IX. GLOSSARY

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Communications	Communications means activities and use of materials created or administered by the Medicare Advantage (MA) organization or any downstream entity to provide information to current and prospective enrollees.
Field Marketing Organization (FMO)	A Field Marketing Organization (FMO) is the same as an independent marketing organization (IMO). FMOs are typically top-level organizations that are licensed to sell health insurance products. It is a company that works with agents, agencies, and brokerages. It supports independent insurance agents in their sales endeavors and client retention. FMOs provide an extra level of support to agents through customer service, marketing and state-of-the art resources and tools. Agents subcontract with FMOs to sell health insurance products.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Independent Agent	An independent agent is an insurance agent who is not employed by any specific insurer and sells issuance policies from multiple companies. They are self-employed and subcontracted by an FMO or Broker Agency. This agent performs education, Marketing, and enrollment tasks for OneCare program and shall possess California Department of Insurance (DOI) licensure, required to be renewed every two (2) years.
Marketing	Activities and use of materials that are conducted by CalOptima Health with the intent to draw a beneficiary's attention to CalOptima Health and to influence a beneficiary's decision- making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about the CalOptima Health's benefit structure, cost sharing, measuring or ranking standards.
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.
Medicare Insurance Broker or Agent	A Medicare insurance broker is typically an independent insurance agent who is licensed to sell Medicare plans on behalf of multiple insurance companies.

Term	Definition
Marketing Activity	Any product or activity intended to encourage retention of or an increase in Contracted Membership or any occasion during which Marketing Materials are presented to Members or persons who may become Members through verbal exchanges or the distribution of Marketing Materials. Marketing Activities may include but are not limited to health fairs, workshops on health promotion, after school programs, raffles, informational sessions hosted by Providers, community-based social gatherings, and posting of Marketing Materials on the internet.
Marketing/Sales Event	Marketing/Sales Events are events designed to steer, or attempt to steer, enrollees or potential enrollees toward a plan or a limited set of plans. At Marketing/Sales Events, the Plan/Part D Sponsor may promote specific benefits/premiums and/or services offered by the plan. Plans/Part D Sponsors may conduct a formal event where a presentation is provided to Medicare beneficiaries or an informal event where Plans/Part D Sponsors are only distributing health plan brochures and pre-enrollment materials. Plans/Part D Sponsors may also accept enrollment forms and perform enrollment at Marketing/Sales Event.
Member	A beneficiary enrolled in a CalOptima Health program.
Talking Points	Talking Points are standardized text. Informational Talking Points are designed to respond to beneficiary questions and requests and provide objective information about a plan or the Medicare program. Sales and enrollment Talking Points are intended to steer a beneficiary towards a plan or limited number of plans, or to enroll a beneficiary into a plan.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Third-Party Marketing Organization (TPMO) Disclaimer

We do not offer every plan available in your area (Orange County, California). Any information we provide is limited to those plans we do offer in your area (Orange County, California). Please contact Medicare.gov or 1-800-MEDICARE to get information on all your options.

إخلاء مسؤولية مؤسسة تسويق الجهة الخارجية

لا نقدم كل خطة متوفرة في منطقتك (مقاطعة أورانج، كاليفورنيا) (Orange County, California). تقتصر أي معلومات نقدمها على الخطط التي نقدمها في منطقتك (مقاطعة أورانج، كاليفورنيا). يُرجى التواصل مع Medicare.gov أو 1-800-MEDICARE للحصول على معلومات بشأن جميع خياراتك.

第三方行銷組織 免責聲明

並非每一種計劃都會在您所在地區 (橙縣, 加州) 提供。我們提供的任何資訊僅適用於我們在您所在地區 (橙縣, 加州) 提供的相關計畫。欲取得有關您所有選項的資訊，請瀏覽 Medicare.gov 或致電 1-800-MEDICARE。

سلب مسئولیت از سازمان بازاریابی شخص ثالث

ما همه برنامه های درمانی موجود در منطقه شما (اورنج کانتی، کالیفرنیا) را ارائه نمی کنیم. هرگونه اطلاعاتی که ارائه می کنیم محدود به برنامه های درمانی می شود که در منطقه شما (اورنج کانتی، کالیفرنیا) ارائه می کنیم. لطفاً برای کسب اطلاعات در مورد همه گزینه های خود با Medicare.gov یا 1-800-MEDICARE تماس بگیرید.

제3자 마케팅 조직면책조항

저희는 귀하의 지역(캘리포니아주 오렌지 카운티)에서 이용 가능한 모든 플랜을 제공하지는 않습니다. 저희가 제공하는 모든 정보는 귀하의 지역(캘리포니아주 오렌지 카운티)에서 제공하는 플랜으로 제한됩니다. 모든 옵션에 대한 정보를 얻으려면 Medicare.gov 또는 1-800-MEDICARE에 문의하십시오.

Descargo de responsabilidad de la organización de mercadotecnia de terceros

No ofrecemos todos los planes disponibles en su área (condado de Orange, California). Cualquier información que proporcionemos se limita a los planes que ofrecemos en su área (condado de Orange, California). Comuníquese con Medicare.gov o al 1-800-MEDICARE para obtener información sobre todas sus opciones.

Minh Định Trách Nhiệm của Cơ Quan Tiếp Thị Bên Thứ Ba

Chúng tôi không cung cấp mọi chương trình hiện có trong khu vực của quý vị (Quận Cam, California). Bất cứ thông tin nào chúng tôi cung cấp đều được giới hạn trong các chương trình mà chúng tôi cung cấp trong khu vực của quý vị (Quận Cam, California). Xin vào trang mạng Medicare.gov hoặc gọi số 1-800-MEDICARE để có thông tin về tất cả các chọn lựa của quý vị.

IR23_MM003_H5433

Title 42 - Public Health
Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter B - Medicare Program
Part 422 - Medicare Advantage Program

ENHANCED CONTENT - TABLE OF CONTENTS

EDITORIAL NOTE ON PART 422

Editorial Note: Nomenclature changes to part 422 appear at 70 FR 4741, Jan. 28, 2005.

Subpart V - Medicare Advantage Communication Requirements

Source: 73 FR 54220, Sept. 18, 2008, unless otherwise noted.

§ 422.2260 Definitions.

The definitions in this section apply for this subpart unless the context indicates otherwise.

Advertisement (Ad) means a read, written, visual, oral, watched, or heard bid for, or call to attention. Advertisements can be considered communications or marketing based on the intent and content of the message.

Alternate format means a format used to convey information to individuals with visual, speech, physical, hearing, and intellectual disabilities (for example, braille, large print, audio).

Banner means a type of advertisement feature typically used in television ads that is intended to be brief, and flashes limited information across a screen for the sole purpose of enticing a prospective enrollee to contact the MA plan (for example, obtain more information) or to alert the viewer that information is forthcoming.

Banner-like advertisement is an advertisement that uses a banner-like feature, that is typically found in some media other than television (for example, outdoors and on the internet).

Communications means activities and use of materials created or administered by the MA organization or any downstream entity to provide information to current and prospective enrollees. Marketing is a subset of communications.

Marketing means communications materials and activities that meet both the following standards for intent and content:

(1) Intended, as determined under paragraph (1)(ii) of this definition, to do any of the following:

(i)

(A) Draw a beneficiary's attention to a MA plan or plans.

(B) Influence a beneficiary's decision-making process when making a MA plan selection.

(C) Influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing).

(ii) In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience of the activity or material, other information communicated by the activity or material, timing, and other context of the activity or material and is not limited to the MA organization's stated intent.

(2) Include or address content regarding any of the following:

(i) The plan's benefits, benefits structure, premiums, or cost sharing.

(ii) Measuring or ranking standards (for example, Star Ratings or plan comparisons).

(iii) Rewards and incentives as defined under § 422.134(a).

Outdoor advertising (ODA) means outdoor material intended to capture the attention of a passing audience (for example, billboards, signs attached to transportation vehicles). ODA may be communications or marketing material.

Third-party marketing organization (TPMO) means organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

[86 FR 6103, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022]

§ 422.2261 Submission, review, and distribution of materials.

(a) ***General requirements.*** MA organizations must submit all marketing materials, all election forms, and certain designated communications materials for CMS review.

(1) The Health Plan Management System (HPMS) Marketing Module is the primary system of record for the collection, review, and storage of materials that must be submitted for review.

(2) Materials must be submitted to the HPMS Marketing Module by the MA organization.

(3) Unless specified by CMS, third party and downstream entities are not permitted to submit materials directly to CMS.

(b) ***CMS review of marketing materials and election forms.*** MA organizations may not distribute or otherwise make available any marketing materials or election forms unless one of the following occurs:

(1) CMS has reviewed and approved the material.

(2) The material has been deemed approved; that is, CMS has not rendered a disposition for the material within 45 days (or 10 days if using CMS model or standardized marketing materials as outlined in § 422.2267(e) of this chapter) of submission to CMS; or

(3) The material has been accepted under File and Use, as follows:

(i) The MA organization may distribute certain types of marketing materials, designated by CMS based on the material's content, audience, and intended use, as they apply to potential risk to the beneficiary, 5 days following the submission.

(ii) The MA organization must certify that the material meets all applicable CMS communications and marketing requirements in §§ 422.2260 through 422.2267.

(c) ***CMS review of non-marketing communications materials.*** CMS does not require submission, or submission and approval, of communications materials prior to use, other than the following exceptions.

(1) Certain designated communications materials that are critical to beneficiaries understanding or accessing their benefits (for example, the Evidence of Coverage (EOC).

(2) Communications materials that, based on feedback such as complaints or data gathered through reviews, warrant additional oversight as determined by CMS, to ensure the information being received by beneficiaries is accurate.

(d) ***Standards for CMS review.*** CMS reviews materials to ensure the following:

(1) Compliance with all applicable requirements under §§ 422.2260 through 422.2267.

(2) Benefit and cost information is an accurate reflection of what is contained in the MA organization's bid.

(3) CMS may determine, upon review of such materials, that the materials must be modified, or may no longer be used.

[86 FR 6104, Jan. 19, 2021]

§ 422.2262 General communications materials and activities requirements.

MA organizations may not mislead, confuse, or provide materially inaccurate information to current or potential enrollees.

(a) ***General rules.*** MA organizations must ensure their statements and the terminology used in communications activities and materials adhere to the following requirements:

(1) MA organizations may not do any of the following:

(i) Provide information that is inaccurate or misleading.

(ii) Make unsubstantiated statements, except when used in logos or taglines.

(iii) Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the MA organization.

(iv) Engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas, or vice versa.

(v) Target potential enrollees based on income levels, unless it is a dual eligible special needs plan or comparable plan as determined by the Secretary.

(vi) Target potential enrollees based on health status, unless it is a special needs plan or comparable plan as determined by the Secretary.

(vii) State or imply plans are only available to seniors rather than to all Medicare beneficiaries.

(viii) Employ MA plan names that suggest that a plan is not available to all Medicare beneficiaries, unless it is a special needs plan or comparable plan as determined by the Secretary. This prohibition does not apply to MA plan names in effect prior to July 31, 2000.

(ix) Display the names or logos or both of co-branded network providers on the organization's member identification card, unless the provider names or logos or both are related to the member selection of specific provider organizations (for example, physicians or hospitals).

(x) Use a plan name that does not include the plan type. The plan type should be included at the end of the plan name, for example, “Super Medicare Advantage (HMO).” MA organizations are not required to repeat the plan type when the plan name is used multiple times in the same material.

(xi) Claim they are recommended or endorsed by CMS, Medicare, the Secretary, or HHS.

(xii) Convey that a failure to pay premium will not result in disenrollment, except for factually accurate descriptions of the MA organization's policies adopted in accordance with § 422.74(b)(1) and (d)(1) of this chapter.

(xiii) Use the term “free” to describe a $0 premium, any type of reduction in premium, reduction in deductibles or cost sharing, low-income subsidy, or cost sharing pertaining to dual eligible individuals.

(xiv) Imply that the plan operates as a supplement to Medicare.

(xv) State or imply a plan is available only to or is designed for beneficiaries who are dually eligible for Medicare and Medicaid, unless it is a dual-eligible special needs plan or comparable plan as determined by the Secretary.

(xvi) Market a non-dual eligible special needs plan as if it were a dual-eligible special needs plan.

(xvii) Target marketing efforts primarily to dual eligible individuals, unless the plan is a dual eligible special needs plan or comparable plan as determined by the Secretary.

(xviii) Claim a relationship with the state Medicaid agency, unless a contract to coordinate Medicaid services for enrollees in that plan is in place.

(2) MA organizations may do the following:

(i) State that the MA organization is approved to participate in Medicare programs or is contracted to administer Medicare benefits or both.

(ii) Use the term “Medicare-approved” to describe benefits or services in materials or both.

(iii) Use the term “free” in conjunction with mandatory, supplemental, and preventative benefits provided at a zero cost share for all enrollees.

(b) ***Product endorsements and testimonials.***

(1) Product endorsements and testimonials may take any of the following forms:

(i) Television or video ads.

(ii) Radio ads.

(iii) Print ads.

(iv) Social media ads. In cases of social media, the use of a previous post, whether or not associated with or originated by the MA organization, is considered a product endorsement or testimonial.

(v) Other types of ads.

(2) MA organizations may use individuals to endorse the MA organization's product provided the endorsement or testimonial adheres to the following requirements:

(i) The speaker must identify the MA organization's product or company by name.

(ii) Medicare beneficiaries endorsing or promoting the MA organization must have been an enrollee at the time the endorsement or testimonial was created.

(iii) The endorsement or testimonial must clearly state that the individual was paid for the endorsement or testimonial, if applicable.

(iv) If an individual is used (for example, an actor) to portray a real or fictitious situation, the endorsement or testimonial must state that it is an actor portrayal.

(c) ***Requirements when including certain telephone numbers in materials.***

(1) MA organizations must adhere to the following requirements for including certain telephone numbers in materials:

(i) When a MA organization includes its customer service number, the hours of operation must be prominently included at least once.

(ii) When a MA organization includes its customer service number, it must provide a toll-free TTY number in conjunction with the customer service number in the same font size.

(iii) On every material where 1-800-MEDICARE or Medicare TTY appears, the MA organization must prominently include, at least once, the hours and days of operation for 1-800-MEDICARE (that is, 24 hours a day/7 days a week).

(2) The following advertisement types are exempt from these requirements:

(i) Outdoor advertising.

(ii) Banners or banner-like ads.

(iii) Radio advertisements and sponsorships.

(d) ***Standardized material identification (SMID).***

(1) MA organizations must use a standardized method of identification for oversight and tracking of materials received by beneficiaries.

(2) The SMID consists of the following three parts:

(i) The MA organization contract or Multi-Contract Entity (MCE) number (that is, “H” for MA or Section 1876 Cost Plans, “R” for Regional PPO plans (RPPOs), or “Y” for MCE, a means of identification available for Plans/Part D sponsors that have multiple MA contracts) followed by an underscore, except that the SMID for multi-plan marketing materials

must begin with the word “MULTI-PLAN” instead of the MA organization's contract number (for example, H1234_abc123_C or MULTI-PLAN_efg456_M).

(ii) A series of alpha numeric characters (chosen at the MA organization's discretion) unique to the material followed by an underscore.

(iii) An uppercase “C” for communications materials or an uppercase “M” for marketing materials (for example, H1234_abc123_C or H5678_efg456_M).

(3) The SMID is required on all materials except the following:

(i) Membership ID card.

(ii) Envelopes, radio ads, outdoor advertisements, banners, banner-like ads, and social media comments and posts.

(iii) OMB-approved forms/documents, except those materials specified in § 422.2267.

(iv) Corporate notices or forms (that is, not MA/Part D specific) meeting the definition of communications (see § 422.2260) such as privacy notices and authorization to disclose protected health information (PHI).

(v) Agent-developed communications materials that are not marketing.

(4) Non-English and alternate format materials, based on previously created materials, may have the same SMID as the material on which they are based.

[86 FR 6104, Jan. 19, 2021]

§ 422.2263 General marketing requirements.

Marketing is a subset of communications and therefore must follow the requirements outlined in § 422.2262 as well as this section. Marketing (as defined in § 422.2260) must additionally meet the following requirements:

(a) MA organizations may begin marketing prospective plan year offerings on October 1 of each year for the following contract year. MA organizations may market the current and prospective year simultaneously provided materials clearly indicate what year is being discussed.

(b) In marketing, MA organizations may not do any of the following:

(1) Provide cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) Offer gifts to beneficiaries, unless the gifts are of nominal value (as governed by guidance published by the HHS OIG), are offered to similarly situated beneficiaries without regard to whether or not the beneficiary enrolls, and are not in the form of cash or other monetary rebates.

(3) Provide meals to potential enrollees regardless of value.

(4) Market non-health care related products to prospective enrollees during any MA sales activity or presentation. This is considered cross-selling and is prohibited.

(5) Compare their plan to other plans, unless the information is accurate, not misleading, and can be supported by the MA organization making the comparison.

(6) Display the names or logos or both of provider co-branding partners on marketing materials, unless the materials clearly indicate via a disclaimer or in the body that “Other providers are available in the network.”

(7) Knowingly target or send unsolicited marketing materials to any MA enrollee during the Open Enrollment Period (OEP).

(i) During the OEP, an MA organization may do any of the following:

(A) Conduct marketing activities that focus on other enrollment opportunities, including but not limited to marketing to age-ins (who have not yet made an enrollment decision), marketing by 5-star plans regarding their continuous enrollment special election period (SEP), and marketing to dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first 9 months of the year;

(B) Send marketing materials when a beneficiary makes a proactive request;

(C) At the beneficiary's request, have one-on-one meetings with a sales agent;

(D) At the beneficiary's request, provide information on the OEP through the call center; and

(E) Include educational information, excluding marketing, on the MA organization's website about the existence of OEP.

(ii) During the OEP, an MA organization may not:

(A) Send unsolicited materials advertising the ability or opportunity to make an additional enrollment change or referencing the OEP;

(B) Specifically target beneficiaries who are in the OEP because they made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification;

(C) Engage in or promote agent or broker activities that intend to target the OEP as an opportunity to make further sales; or

(D) Call or otherwise contact former enrollees who have selected a new plan during the AEP.

(c) The following requirements apply to how MA organizations must display CMS-issued Star Ratings:

(1) References to individual Star Rating measure(s) must also include references to the overall Star Rating for MA-PDs and the summary rating for MA-only plans.

(2) May not use an individual underlying category, domain, or measure rating to imply overall higher Star Ratings.

(3) Must be clear that the rating is out of 5 stars.

(4) Must clearly identify the Star Ratings contract year.

(5) May only market the Star Ratings in the service area(s) for which the Star Rating is applicable, unless using Star Ratings to convey overall MA organization performance (for example, “Plan X has achieved 4.5 stars in Montgomery, Chester, and Delaware Counties), in which case the MA organization must do so in a way that is not confusing or misleading.

(6) The following requirements apply to all 5 Star MA contracts:

(i) May not market the 5-star special enrollment period, as defined in § 422.62(b)(15), after November 30 of each year if the contract has not received an overall 5 star for the next contract year.

(ii) May use CMS' 5-star icon or may create their own icon.

(7) The following requirements apply to all Low Performing MA contracts:

(i) The Low Performing Icon must be included on all materials about or referencing the specific contract's Star Ratings.

(ii) Must state the Low Performing Icon means that the MA organization's contract received a summary rating of 2.5 stars or below in Part C or Part D or both for the last 3 years.

(iii) May not attempt to refute or minimize Low Performing Status.

[86 FR 6105, Jan. 19, 2021]

§ 422.2264 Beneficiary contact.

For the purpose of this section, beneficiary contact means any outreach activities to a beneficiary or a beneficiary's caregivers by the MA organization or its agents and brokers.

(a) ***Unsolicited contact.*** Subject to the rules for contact for plan business in paragraph (b) of this section, the following rules apply when materials or activities are given or supplied to a beneficiary or their caregiver without prior request:

(1) MA organizations may make unsolicited direct contact by conventional mail and other print media (for example, advertisements and direct mail) or email (provided every email contains an opt-out option).

(2) MA organizations may not do any of the following if unsolicited:

(i) Use door to door solicitation, including leaving information of any kind, except that information may be left when an appointment is pre-scheduled but the beneficiary is not home.

(ii) Approach enrollees in common areas such as parking lots, hallways, and lobbies.

(iii) Send direct messages from social media platforms.

(iv) Use telephone solicitation (that is, cold calling), robocalls, text messages, or voicemail messages, including, but not limited to, the following:

(A) Calls based on referrals.

(B) Calls to former enrollees who have disenrolled or those in the process of disenrolling, except to conduct disenrollment surveys for quality improvement purposes.

(C) Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission to be contacted.

(D) Calls to prospective enrollees to confirm receipt of mailed information.

(3) Calls are not considered unsolicited if the beneficiary provides consent or initiates contact with the plan. For example, returning phone calls or calling an individual who has completed a business reply card requesting contact is not considered unsolicited.

(b) ***Contact for plan business.*** MA organizations may contact current, and to a more limited extent, former members, including those enrolled in other products offered by the parent organization, to discuss plan business, in accordance with the following requirements:

(1) An MA organization may conduct the following activities as plan business:

(i) Call current enrollees, including those in non-Medicare products, to discuss Medicare products. Examples of such calls include, but are not limited to the following:

(A) Enrollees aging into Medicare from commercial products.

(B) Existing enrollees, including Medicaid enrollees, to discuss other Medicare products or plan benefits.

(C) Members in a Part D plan to discuss other Medicare products.

(ii) Call beneficiaries who submit enrollment applications to conduct business related to enrollment.

(iii) With prior CMS approval, call LIS enrollees that a plan is prospectively losing due to reassignment. CMS decisions to approve calls are for limited circumstances based on the following:

(A) The proximity of cost of the losing plan as compared to the national benchmark; and

(B) The selection of plans in the service area that are below the benchmark.

(iv) Agents/brokers calling clients who are enrolled in other products they may sell, such as automotive or home insurance.

(v) MA organizations may not make unsolicited calls about other lines of business as a means of generating leads for Medicare plans.

(2) When reaching out to a beneficiary regarding plan business, as outlined in this section, MA organizations must offer the beneficiary the ability to opt out of future calls regarding plan business.

(c) ***Events with beneficiaries.*** MA organizations and their agents or brokers may hold educational events, marketing or sales events, and personal marketing appointments to meet with Medicare beneficiaries, either face-to-face or virtually. The requirements for each type of event are as follows:

(1) Educational events must be advertised as such and be designed to generally inform beneficiaries about Medicare, including Medicare Advantage, Prescription Drug programs, or any other Medicare program.

(i) At educational events, MA organizations and agents/brokers may not market specific MA plans or benefits.

(ii) MA organizations holding or participating in educational events may do any of the following:

(A) Distribute communications materials.

(B) Answer beneficiary-initiated questions pertaining to MA plans.

(C) Set up future personal marketing appointments.

(D) Distribute business cards.

(E) Obtain beneficiary contact information, including Scope of Appointment forms.

(iii) MA organizations holding or participating in educational events may not conduct sales or marketing presentations or distribute or accept plan applications.

(iv) MA organizations may schedule appointments with residents of long-term care facilities (for example, nursing homes, assisted living facilities, board and care homes) upon a resident's request. If a resident did not request an appointment, any visit by an agent or broker is prohibited as unsolicited door-to-door marketing.

(2) Marketing or sales events are group events that fall within the definition of marketing at § 422.2260.

(i) If a marketing event directly follows an educational event, the beneficiary must be made aware of the change and given the opportunity to leave prior to the marketing event beginning.

(ii) MA organizations holding or participating in marketing events may do any of the following:

(A) Provide marketing materials.

(B) Distribute and accept plan applications.

(C) Collect Scope of Appointment forms for future personal marketing appointments.

(D) Conduct marketing presentations.

(iii) MA organizations holding or participating in marketing events may not do any of the following:

(A) Require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event.

(B) Conduct activities, including health screenings, health surveys, or other activities that are used for or could be viewed as being used to target a subset of members (that is, “cherry-picking”).

(C) Use information collected for raffles or drawings for any purpose other than raffles or drawings.

(3) Personal marketing appointments are those appointments that are tailored to an individual or small group (for example, a married couple). Personal marketing appointments are not defined by the location.

(i) Prior to the personal marketing appointment beginning, the MA plan (or agent or broker, as applicable) must agree upon and record the Scope of Appointment with the beneficiary(ies).

(ii) MA organizations holding a personal marketing appointment may do any of the following:

(A) Provide marketing materials.

(B) Distribute and accept plan applications.

(C) Conduct marketing presentations.

(D) Review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns.

(iii) MA organizations holding a personal marketing appointment may not do any of the following:

(A) Market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment.

(B) Market additional health related lines of plan business not identified prior to an individual appointment without a separate Scope of Appointment identifying the additional lines of business to be discussed.

(C) Market non-health related products, such as annuities.

[86 FR 6106, Jan. 19, 2021]

§ 422.2265 Websites.

As required under § 422.111(h)(2), MA organizations must have a website.

(a) ***General website requirements.***

(1) MA organization websites must meet all of the following requirements:

(i) Maintain current year contract content through December 31 of each year.

(ii) Notify users when they will leave the MA organization's Medicare site.

(iii) Include or provide access to (for example, through a hyperlink) applicable notices, statements, disclosures, or disclaimers with corresponding content. Overarching disclaimers, such as the Federal Contracting Statement, are not required on every page.

(iv) Reflect the most current information within 30 days of any material change.

(v) Keep MA content separate and distinct from other lines of business, including Medicare Supplemental Plans.

(2) MA organization websites may not do any of the following:

(i) Require beneficiaries to enter any information other than zip code, county, or state for access to non-beneficiary-specific website content.

(ii) Provide links to foreign drug sales, including advertising links.

(iii) State that the MA organization is not responsible for the content of their social media pages or the website of any first tier, downstream, or related entity that provides information on behalf of the MA organization.

(b) ***Required content.*** MA organization's websites must include the following content:

(1) A toll-free customer service number, TTY number, and days and hours of operation.

(2) A physical or Post Office Box address.

(3) A PDF or copy of a printable provider directory.

(4) A searchable provider directory.

(5) When applicable, a searchable pharmacy directory combined with a provider directory.

(6) Information on enrollees' and MA organizations' rights and responsibilities upon disenrollment. MA organizations may either post this information or provide specific information on where it is located in the Evidence of Coverage together with a link to that document.

(7) A description of and information on how to file a grievance, request an organization determination, and an appeal.

(8) Prominently displayed link to the Medicare.gov electronic complaint form.

(9) Disaster and emergency policy consistent with § 422.100(m)(5)(iii).

(10) A Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 CFR 164.520).

(11) For PFFS plans, a link to the PFFS Terms and Conditions of Payment.

(12) For MSA plans, the following statements:

(i) "You must file Form 1040, `US Individual Income Tax Return,' along with Form 8853, `Archer MSA and Long-Term Care Insurance Contracts' with the Internal Revenue Service (IRS) for any distributions made from your Medicare MSA account to ensure you aren't taxed on your MSA account withdrawals. You must file these tax forms for any year in which an MSA account withdrawal is made, even if you have no taxable income or other reason for filing a Form 1040. MSA account withdrawals for qualified medical expenses are tax free, while account withdrawals for non-medical expenses are subject to both income tax and a fifty (50) percent tax penalty."

(ii) "Tax publications are available on the IRS website at *http://www.irs.gov* or from 1-800-TAX-FORM (1-800-829-3676)."

(13) Instructions on how to appoint a representative including a link to the downloadable version of the CMS Appointment of Representative Form (CMS Form-1696).

(14) Enrollment instructions and forms.

(c) ***Required posted materials.*** MA organization's website must provide access to the following materials, in a printable format, within the timeframes specified in paragraphs (c)(1) and (2) of this section.

(1) The following materials for each plan year must be posted on the website by October 15 prior to the beginning of the plan year:

(i) Evidence of Coverage.

(ii) Annual Notice of Change (for renewing plans).

(iii) Summary of Benefits.

(iv) Provider Directory.

(v) Provider/Pharmacy Directory.

(2) The following materials must be posted on the website throughout the year and be updated as required:

(i) Prior Authorization Forms for physicians and enrollees.

(ii) When applicable, Part D Model Coverage Determination and Redetermination Request Forms.

(iii) Exception request forms for physicians (which must be posted by January 1 for new plans).

(iv) CMS Star Ratings document, which must be posted within 21 days after its release on the Medicare Plan Finder.

[86 FR 6107, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022]

§ 422.2266 Activities with healthcare providers or in the healthcare setting.

(a) ***Where marketing is prohibited.*** The requirements in paragraphs (c) through (e) of this section apply to activities in the health care setting. Marketing activities and materials are not permitted in areas where care is being administered, including but not limited to the following:

(1) Exam rooms.

(2) Hospital patient rooms.

(3) Treatment areas where patients interact with a provider and clinical team (including such areas in dialysis treatment facilities).

(4) Pharmacy counter areas.

(b) ***Where marketing is permitted.*** Marketing activities and materials are permitted in common areas within the health care setting, including the following:

(1) Common entryways.

(2) Vestibules.

(3) Waiting rooms.

(4) Hospital or nursing home cafeterias.

(5) Community, recreational, or conference rooms.

(c) ***Provider-initiated activities.*** Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. Provider-initiated activities that meet the definition in this paragraph (c) fall outside of the definition of marketing in § 422.2260. Permissible provider-initiated activities include:

(1) Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from *https://www.medicare.gov*), including in areas where care is delivered.

(2) Providing the names of MA organizations with which they contract or participate or both.

(3) Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered.

(4) Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS' website at *https://www.medicare.gov,* or 1-800-MEDICARE.

(5) Referring patients to MA plan marketing materials available in common areas;

(6) Providing information and assistance in applying for the LIS.

(7) Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

(d) ***Plan-initiated provider activities.*** Plan-initiated provider activities are those activities conducted by a provider at the request of an MA organization. During a plan-initiated provider activity, the provider is acting on behalf of the MA organization. For the purpose of plan-initiated activities, the MA organization is responsible for compliance with all applicable regulatory requirements.

(1) During plan-initiated provider activities, MA organizations must ensure that the provider does not:

(i) Accept or collect Scope of Appointment forms.

(ii) Accept Medicare enrollment applications.

(iii) Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.

(iv) Mail marketing materials on behalf of the MA organization.

(v) Offer inducements to persuade patients to enroll in a particular MA plan or organization.

(vi) Conduct health screenings as a marketing activity.

(vii) Distribute marketing materials or enrollment forms in areas where care is being delivered.

(viii) Offer anything of value to induce enrollees to select the provider.

(ix) Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

(2) During plan-initiated provider activities, the provider may do any of the following:

(i) Make available, distribute, and display communications materials, including in areas where care is being delivered.

(ii) Provide or make available marketing materials and enrollment forms in common areas.

(e) ***MA organization activities in the health care setting.*** MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider. All marketing must comply with the requirements in paragraphs (a) and (b) of this section. However, during MA organization activities, the following is permitted:

(1) Accepting and collect Scope of Appointment forms.

(2) Accepting enrollment forms.

(3) Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

(f) ***Activities of Institutional Special Needs Plans (I-SNPs) Serving Long-Term Care Facility Residents***

(1) Depending on the context of a given situation, I-SNP contracted with a long-term care facility can be viewed as both a provider and a plan.

(2) I-SNPs may use staff operating in a social worker capacity to provide information, including marketing materials (excluding enrollment forms), to residents of a long term care facility.

(3) Social workers of the I-SNP (whether employees, agents, or contracted providers) may not accept or collect a scope of appointment or enrollment form on behalf of the I-SNP.

(4) Unless the beneficiary or the beneficiary's authorized representative initiates additional contact with or by the plan, all other marketing and outreach activities in the beneficiary's room must follow the requirements for beneficiary contact under § 422.2264

(5) All other activities with healthcare providers or in the healthcare setting must comply with §§ 422.2266(a), (b), (c), (d), and (e).

[86 FR 6108, Jan. 19, 2021]

§ 422.2267 Required materials and content.

For information CMS deems to be vital to the beneficiary, including information related to enrollment, benefits, health, and rights, the agency may develop materials or content that are either standardized or provided in a model form. Such materials and content are collectively referred to as required.

(a) ***Standards for required materials and content.*** All required materials and content, regardless of categorization as standardized in paragraph (b) of this section or model in paragraph (c) of this section, must meet the following:

(1) Be in a 12pt font, Times New Roman or equivalent.

(2) For markets with a significant non-English speaking population, be in the language of these individuals. Specifically, MA organizations must translate required materials into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area.

(3) Be provided to the beneficiary within CMS's specified timeframes.

(b) ***Standardized materials.*** Standardized materials and content are required materials and content that must be used in the form and manner provided by CMS.

(1) When CMS issues standardized material or content, an MA organization must use the document without alteration except for the following:

(i) Populating variable fields.

(ii) Correcting grammatical errors.

(iii) Adding customer service phone numbers.

(iv) Adding plan name, logo, or both.

(v) Deleting content that does not pertain to the plan type (for example, removing Part D language for a MA-only plan).

(vi) Adding the SMID.

(vii) A Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 CFR 164.520).

(2) The MA organization may develop accompanying language for standardized material or content, provided that language does not conflict with the standardized material or content. For example, CMS may issue standardized content associated with an appeal notification and MA organizations may draft a letter that includes the standardized content in the body of the letter; the remaining language in the letter is at the plan's discretion, provided it does not conflict with the standardized content or other regulatory standards.

(c) ***Model materials.*** Model materials and content are those required materials and content created by CMS as an example of how to convey beneficiary information. When drafting required materials or content based on CMS models, MA organizations:

(1) Must accurately convey the vital information in the required material or content to the beneficiary, although the MA organization is not required to use CMS model materials or content verbatim; and

(2) Must follow CMS's specified order of content, when specified.

(d) ***Delivery of required materials.*** MA organizations must mail required materials in hard copy or provide them electronically, following the requirements in paragraphs (d)(1) and (2) of this section.

(1) For hard copy mailed materials, each enrollee must receive his or her own copy, except in cases of non-beneficiary-specific material(s) where the MA organization has determined multiple enrollees are living in the same household and it has reason to believe the enrollees are related. In that case, the MA organization may mail one copy to the household. The MA organization must provide all enrollees an opt-out process so the enrollees can each receive his or her own copy, instead of a copy to the household. Materials specific to an individual beneficiary must always be mailed to that individual.

(2) Materials may be delivered electronically following the requirements in paragraphs (d)(2)(i) and (ii) of this section.

(i) Without prior authorization from the enrollee, MA organizations may mail new and current enrollees a notice informing enrollees how to electronically access the following required materials: the Evidence of Coverage, Provider and Pharmacy Directories, and Formulary. The following requirements apply:

(A) The MA organization may mail one notice for all materials or multiple notices.

(B) Notices for prospective year materials may not be mailed prior to September 1 of each year, but must be sent in time for an enrollee to access the specified materials by October 15 of each year.

(C) The MA organization may send the notice throughout the year to new enrollees.

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(D) The notice must include the website address to access the materials, the date the materials will be available if not currently available, and a phone number to request that hard-copy materials be mailed.

(E) The notice must provide the enrollee with the option to request hardcopy materials. Requests may be material specific, and must have the option of a one-time request or a permanent request that must stay in place until the enrollee chooses to receive electronic materials again.

(F) Hard copies of requested materials must be sent within three business days of the request.

(ii) With prior authorization from the enrollee, MA organizations may provide any required material or content electronically. To do so, MA organizations must:

(A) Obtain prior consent from the enrollee. The consent must specify both the media type and the specific materials being provided in that media type.

(B) Provide instructions on how and when enrollees can access the materials.

(C) Have a process through which an enrollee can request hard copies be mailed, providing the beneficiary with the option of a one-time request or a permanent request (which must stay in place until the enrollee chooses to receive electronic materials again), and with the option of requesting hard copies for all or a subset of materials. Hard copies must be mailed within three business days of the request.

(D) Have a process for automatic mailing of hard copies when electronic versions or the chosen media type is undeliverable.

(e) ***CMS required materials and content.*** The following are required materials that must be provided to current and prospective enrollees, as applicable, in the form and manner outlined in this section. Unless otherwise noted or instructed by CMS and subject to § 422.2263(a) of this chapter, required materials may be sent once a fully executed contract is in place, but no later than the due dates listed for each material in this section.

(1) ***Evidence of Coverage (EOC).*** The EOC is a standardized communications material through which certain required information (under § 422.111(b)) must be provided annually and must be provided:

(i) To current enrollees of the plan by October 15, prior to the year to which the EOC applies.

(ii) To new enrollees within 10 calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(2) ***Part C explanation of benefits (EOB).*** The EOB is a model communications material through which plans must provide the information required under § 422.111(k). MA organizations may send this monthly or per claim with a quarterly summary.

(3) ***Annual notice of change (ANOC).*** The ANOC is a standardized marketing material through which plans must provide the information required under § 422.111(d)(2) annually.

(i) Must send for enrollee receipt no later than September 30 of each year.

(ii) Enrollees with an October 1, November 1, or December 1 effective date must receive within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(4) ***Pre-Enrollment checklist (PECL).*** The PECL is a standardized communications material that plans must provide to prospective enrollees with the enrollment form, so that the enrollees understand important plan benefits and rules. It references information on the following:

(i) The EOC.

(ii) Provider directory.

(iii) Pharmacy directory.

(iv) Formulary.

(v) Premiums/copayments/coinsurance.

(vi) Emergency/urgent coverage.

(vii) Plan-type rules.

(5) ***Summary of Benefits (SB).*** MA organizations must disseminate a summary of highly utilized coverage that include benefits and cost sharing to prospective enrollees, known as the SB. The SB is a model marketing material. It must be in a clear and accurate form.

(i) The SB must be provided with an enrollment form as follows:

(A) In hard copy with a paper enrollment form.

(B) For online enrollment, the SB must be made available electronically (for example, via a link) prior to the completion and submission of enrollment request.

(C) For telephonic enrollment, the beneficiary must be verbally told where the SB can be accessed.

(ii) The SB must include the following information:

(A) Information on medical benefits, including:

(*1*) Monthly Plan Premium.

(*2*) Deductible/Out-of-pocket limits.

(*3*) Inpatient/Outpatient Hospital coverage.

(*4*) Ambulatory Surgical Center (ASC).

(*5*) Doctor Visits (Primary Care Providers and Specialists).

(*6*) Preventive Care.

(*7*) Emergency Care/Urgently Needed Services.

(*8*) Diagnostic Services/Labs/Imaging.

(*9*) Hearing Services/Dental Services/Vision Services.

(*10*) Mental Health Services.

(B) Information on prescription drug expenses, including:

(*1*) Deductible, the initial coverage phase, coverage gap, and catastrophic coverage.

(*2*) A statement that costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30-or 90-day supply), when applicable.

(C) For Medicare Medical Savings Account Plans (MSAs), the SB must include the following:

(*1*) The amount Medicare deposits into the beneficiaries MSA account.

(*2*) A statement that the beneficiary pays nothing once the deductible is met.

(D) For dual eligible special needs plan (D-SNP)s, the SB must identify or describe the Medicaid benefits to prospective enrollees. This may be done by either of the following:

(*1*) Including the Medicaid benefits in the SB.

(*2*) Providing a separate document identifying the Medicaid benefits that accompanies the SB.

(E) For D-SNPs open to dually eligible enrollees with differing levels of cost, the SB must:

(*1*) State how cost sharing and benefits differ depending on the level of Medicaid eligibility.

(*2*) Describe the Medicaid benefits, if any, provided by the plan.

(F) Fully integrated dual eligible SNPs (FIDE SNPs) and highly integrated D-SNPs, as defined in § 422.2, that provide Medicaid benefits have the option to display integrated Medicare and Medicaid benefits in the SB.

(G) MA organizations may describe or identify other health related benefits in the SB.

(6) ***Enrollment/Election form.*** This is a model communications material through which plans must provide the information required under § 422.60(c).

(7) ***Enrollment Notice.*** This is a model communications material through which plans must provide the information required under § 422.60(e)(3).

(8) ***Disenrollment Notice.*** This is a model communications material through which plans must provide the information required under § 422.74(b).

(9) ***Mid-Year Change Notification.*** This is a model communications material through which plans must provide a notice to enrollees when there is a mid-year change in benefits or plan rules, under the following timelines:

(i) Notices of changes in plan rules, unless otherwise addressed elsewhere in this part, must be provided 30 days in advance.

(ii) For National Coverage Determination (NCD) changes announced or finalized less than 30 days before their effective date, a notification is required as soon as possible.

(iii) Mid-year NCD or legislative changes must be provided no later than 30 days after the NCD is announced or the legislative change is effective.

(A) Plans may include the change in next plan mass mailing (for example, newsletter), provided it is within 30 days.

(B) The notice must also appear on the MA organization's website.

(10) ***Non-renewal Notice.*** This is a model communications material through which plans must provide the information required under § 422.506.

(i) The Non-renewal Notice must be provided at least 90 calendar days before the date on which the nonrenewal is effective. For contracts ending on December 31, the notice must be dated October 2 to ensure national consistency in the application of Medigap Guaranteed Issue (GI) rights to all enrollees, except for those enrollees in special needs plans (SNPs). Information about non-renewals or service area reductions may not be released to the public, including the Non-renewal Notice, until CMS provides notification to the plan.

(ii) The Non-renewal Notice must do all of the following:

(A) Inform the enrollee that the plan will no longer be offered and the date the plan will end.

(B) Provide information about any applicable open enrollment periods or special election periods or both (for example, Medicare open enrollment, non-renewal special election period), including the last day the enrollee has to make a Medicare health plan selection.

(C) Explain what the enrollee must do to continue receiving Medicare coverage and what will happen if the enrollee chooses to do nothing.

(D) As required under § 422.506(a)(2)(ii)(A), provide a CMS-approved written description of alternative MA plan, MA-PD plan, and PDP options available for obtaining qualified Medicare services within the beneficiary's' region in the enrollee's notice.

(E) Specify when coverage will start after a new Medicare plan is chosen.

(F) List 1-800-MEDICARE contact information together with other organizations that may be able to assist with comparing plans (for example, SHIPs).

(G) Explain Medigap to applicable enrollees and the special right to buy a Medigap policy, and include a Medigap fact sheet with the non-renewal notice that explains Medigap coverage, policy, options to compare Medigap policies, and options to buy a Medigap policy.

(H) Include the MA organization's call center telephone number, TTY number, and hours and days of operation.

(11) ***Provider Directory.*** This is a model communications material through which plans must provide the information under § 422.111(b)(3). The Provider Directory must:

(i) Be provided to current enrollees of the plan by October 15 of the year prior to the applicable year.

(ii) Be provided to new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(iii) Be provided to current enrollees upon request, within three business days of the request.

(iv) Be updated any time the MA organization becomes aware of changes.

(A) Updates to the online provider directories must be completed within 30 days of receiving information requiring update.

(B)

(*1*) Updates to hardcopy provider directories must be completed within 30 days.

(*2*) Hard copy directories that include separate updates via addenda are considered up-to-date.

(12) ***Provider Termination Notice.*** This is a model communications material through which plans must provide the information required under § 422.111(e). The provider termination notice must be both of the following:

(i) Provided in hard copy.

(ii) Sent via U.S. mail (first class postage is recommended, but not required).

(13) ***Star Ratings Document.*** This is a standardized marketing material through which Star Ratings information is conveyed to prospective enrollees.

(i) The Star Ratings Document is generated through HPMS.

(ii) The Star Ratings Document must be provided with an enrollment form, as follows:

(A) In hard copy with a paper enrollment form.

(B) For online enrollment, made available electronically (for example, via a link) prior to the completion and submission of enrollment request.

(C) For telephonic enrollment, the beneficiary must be verbally told where they can access the Star Ratings Document.

(iii) New MA organizations that have no Star Ratings are not required to provide the Star Ratings Document until the following contract year.

(iv) Updated Star Ratings must be used within 21 calendar days of release of updated information on Medicare Plan Finder.

(v) Updated Star Ratings must not be used until CMS releases Star Ratings on Medicare Plan Finder.

(14) ***Organization Determination Notice.*** This is a model communications material through which plans must provide the information under § 422.568.

(15) ***Excluded Provider Notice.*** This is a model communications material through which plans must notify enrollees when a provider they visit or consult has been excluded from participating in the Medicare program based on an OIG exclusion or the CMS preclusion list.

(16) ***Notice of Denial of Medical Coverage or Payment (NDMCP) (also known as the Integrated Denial Notice (IDN)).*** This is a standardized communications material used to convey beneficiary appeal rights when a plan has denied a service as non-covered or excluded from benefits.

(17) ***Notice of Medicare Non-Coverage (NOMNC).*** This is a standardized communications material used to convey beneficiary appeal rights when a plan is terminating previously-approved coverage in a Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), or Home Health setting (HHA).

(18) ***Detailed Explanation of Non-Coverage (DENC).*** This is a standardized communications material used to convey to a beneficiary why their current Medicare covered SNF, CORF or HHA services should end.

(19) ***Appointment of Representative (AOR).*** This is a standardized communications material used to authorize or appoint an individual to act on behalf of a beneficiary for the purpose of a specific appeal, grievance, or organization determination.

(20) ***An Important Message From Medicare About Your Rights (IM).*** This is a standardized communications material used to convey a beneficiary's rights as a hospital inpatient and appeal rights when their covered inpatient hospital stay is ending.

(21) ***Detailed Notice of Discharge Form (DND).*** This is a standardized communications material, as required under § 422.622(e), used to convey to a beneficiary why their current Medicare covered inpatient hospital stay should end.

(22) ***Medicare Outpatient Observation Notice (MOON).*** This is a standardized communications material used to inform a beneficiary that he or she is an outpatient receiving observation services.

(23) ***Appeal and Grievance Data Form.*** This is a standardized communications material used to convey organization-specific grievance and appeals data.

(24) ***Request for Administrative Law Judge (ALJ) Hearing.*** This is a standardized communications material used to formally request a reconsideration of the independent review entity's determination.

(25) ***Attorney Adjudicator Review in Lieu of ALJ Hearing.*** This is a standardized communications material used to request that an attorney adjudicator review a previously determined decision rather than having an ALJ do so.

(26) ***Notice of Right to an Expedited Grievance.*** This is a model communications material used to convey a Medicare enrollee's rights to request that a decision be made on a grievance or appeal within a shorter timeframe.

(27) ***Waiver of Liability Statement.*** This is a model communications material used by non-contracted providers to waive beneficiary liability for payment for denied services while utilizing the enrollee appeals process under subpart M of part 422.

(28) ***Notice of Appeal Status.*** This is a model communications material used to inform a beneficiary of the denial of an appeal and additional appeal rights.

(29) ***Notice of Dismissal of Appeal.*** This is a model communications material used to convey the rationale by an MA organization to dismiss beneficiary's appeal.

(30) ***Member ID card.*** The member ID card is a model communications material that plans must provide to enrollees as required under § 422.111(i). The member ID card -

(i) Must be provided to new enrollees within ten calendars days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the plan effective date, whichever is later;

(ii) Must include the plan's -

(A) Website address;

(B) Customer service number (the member ID card is excluded from the hours of operations requirement under § 422.2262(c)(1)(i)); and

(C) Contract/PBP number;

(iii) Must include, if issued for a PPO and PFFS plan, the phrase “Medicare limiting charges apply.”;

(iv) May not use a member's Social Security number (SSN), in whole or in part;

(v) Must be updated whenever information on a member's existing card changes; in such cases an updated card must be provided to the member;

(vi) Is excluded from the translation requirement under paragraph (a)(2) of this section; and

(vii) Is excluded from the 12-point font size requirement under paragraph (a)(1) of this section.

(31) ***Multi-language insert (MLI).*** This is a standardized communications material which states, “We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service.” in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese.

(i) Additional languages that meet the 5-percent service area threshold, as required under paragraph (a)(2) of this section, must be added to the MLI used in that service area. A plan may also opt to include in the MLI any additional language that do not meet the 5-percent service area threshold, where it determines that this inclusion would be appropriate.

(ii) The MLI must be provided with all required materials under paragraph (e) of this section.

(iii) The MLI may be included as a part of the required material or as a standalone material in conjunction with the required material.

(iv) When used as a standalone material, the MLI may include organization name and logo.

(v) When mailing multiple required materials together, only one MLI is required.

(vi) The MLI may be provided electronically when a required material is provided electronically as permitted under paragraph (d)(2) of this section.

(32) ***Federal Contracting Statement.*** This is model content through which plans must convey that they have a contract with Medicare and that enrollment in the plan depends on contract renewal.

(i) The Federal Contracting Statement must include all of the following:

(A) Legal or marketing name of the organization.

(B) Type of plan (for example, HMO, HMO SNP, PPO, PFFS, PDP).

(C) A statement that the organization has a contract with Medicare (when applicable, MA organizations may incorporate a statement that the organization has a contract with the state/Medicaid program).

(D) A statement that enrollment depends on contract renewal.

(ii) MA organizations must include the Federal Contracting Statement on all marketing materials with the exception of the following:

(A) Banners and banner-like advertisements.

(B) Outdoor advertisements.

(C) Text messages.

(D) Social media.

(E) Envelopes.

(33) ***Star Ratings Disclaimer.*** This is model content through which plans must:

(i) Convey that MA organizations are evaluated yearly by Medicare.

(ii) Convey that the ratings are based on a 5-star rating system.

(iii) Include the model content in disclaimer form or within the material whenever Star Ratings are mentioned in marketing materials, with the exception of when Star Ratings are published on small objects (that is, a give-away items such as a pens or rulers).

(34) ***SSBCI Disclaimer.*** This is model content through which MA organizations must:

(i) Convey the benefits mentioned are a part of special supplemental benefits.

(ii) Convey that not all members will qualify.

(iii) Include the model content in the material copy which mentions SSBCI benefits.

(35) ***Accommodations Disclaimer.*** This is model content through which MA organizations must:

(i) Convey that accommodations for persons with special needs are available.

(ii) Provide a telephone number and TTY number.

(iii) Include the model content in disclaimer form or within the body of the material on any advertisement of invitation to all events described under § 422.2264(c).

(36) ***Mailing Statements.*** This is standardized content. It consists of statements on envelopes that MA organizations must include when mailing information to current members, as follows:

(i) MA organizations must include the following statement when mailing information about the enrollee's current plan: “Important [Insert Plan Name] information.”

(ii) MA organizations must include the following statement when mailing health and wellness information: “Health and wellness or prevention information.”

(iii) The MA organization must include the plan name; however, if the plan name is elsewhere on the envelope, the plan name does not need to be repeated in the disclaimer.

(iv) Delegated or sub-contracted entities and downstream entities that conduct mailings on behalf of a multiple MA organizations must also comply with this requirement; however, they do not have to include a plan name.

(37) ***Promotional Give-Away Disclaimer.*** This is model content. The disclaimer consists of a statement that must make clear that there is no obligation to enroll in a plan, and must be included when offering a promotional give-away such as a drawing, prizes, or a free gift.

(38) ***Provider Co-branded Material Disclaimer.*** This is model content through which MA organizations must:

(i) Convey, as applicable, that other pharmacies, physicians or providers are available in the plan's network.

(ii) Include the model content in disclaimer form or within the material whenever co-branding relationships with network provider are mentioned, unless the co-branding is with a provider network or health system that represents 90 percent or more of the network as a whole.

(39) ***Out of Network Non-Contracted Provider Disclaimer.*** This is standardized content. The disclaimer consists of the statement: "Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services," and must be included whenever materials reference out-of-network/non-contracted providers.

(40) ***NCQA SNP Approval Statement.*** This is model content and must be used by SNPs who have received NCQA approval. MA organizations must:

(i) Convey that MA organization has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP).

(ii) Include the last contract year of NCQA approval.

(iii) Convey that the approval is based on a review of [insert Plan Name's] Model of Care.

(iv) Not include numeric SNP approval scores.

(41) ***Third-party marketing organization disclaimer.*** This is standardized content. The disclaimer consists of the statement: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options." The MA organization must ensure that the disclaimer is as follows:

(i) Used by any TPMO, as defined under § 422.2260, that sells plans on behalf of more than one MA organization unless the TPMO sells all commercially available MA plans in a given service area.

(ii) Verbally conveyed within the first minute of a sales call.

(iii) Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.

(iv) Prominently displayed on TPMO websites.

(v) Included in any marketing materials, including print materials and television advertisements, developed, used or distributed by the TPMO.

[86 FR 6108, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022]

§ 422.2272 Licensing of marketing representatives and confirmation of marketing resources.

In its marketing, the MA organization must:

(a) Demonstrate to CMS' satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(b) Establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the MA plan, and understand the rules applicable under the plan.

(c) Employ as marketing representatives only individuals who are licensed by the State to conduct marketing activities (as defined in the Medicare Marketing Guidelines) in that State, and whom the organization has informed that State it has appointed, consistent with the appointment process provided for under State law.

(d) Report to the State in which the MAO appoints an agent or broker, the termination of any such agent or broker, including the reasons for such termination if State law requires that the reasons for the termination be reported.

[73 FR 54220, Sept. 18, 2008, as amended at 73 FR 54250, Sept. 18, 2008; 76 FR 21569, Apr. 15, 2011; 83 FR 16735, Apr. 16, 2018]

§ 422.2274 Agent, broker, and other third-party requirements.

If an MA organization uses agents and brokers to sell its Medicare plans, the requirements in paragraphs (a) through (e) of this section are applicable. If an MA organization makes payments to third parties, the requirements in paragraph (f) of this section are applicable.

(a) ***Definitions.*** For purposes of this section, the following definitions are applicable:

Compensation.

(i) Includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a plan or product offered by an MA organization including, but not limited to the following:

(A) Commissions.

(B) Bonuses.

(C) Gifts.

(D) Prizes or Awards.

(ii) Does not include any of the following:

(A) Payment of fees to comply with State appointment laws, training, certification, and testing costs.

(B) Reimbursement for mileage to, and from, appointments with beneficiaries.

(C) Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

Fair market value (FMV) means, for purposes of evaluating agent or broker compensation under the requirements of this section only, the amount that CMS determines could reasonably be expected to be paid for an enrollment or continued enrollment into an MA plan. Beginning January 1, 2021, the national FMV is $539, the FMV for Connecticut, Pennsylvania, and the District of Columbia is $607, the FMV for California and New Jersey is $672, and the FMV for Puerto Rico and the U.S. Virgin Islands is $370. For subsequent years, FMV is calculated by adding the current year FMV and the product of the current year FMV and MA Growth Percentage for aged and disabled beneficiaries, which is published for each year in the rate announcement issued pursuant to § 422.312.

Initial enrollment year means the first year that a beneficiary is enrolled in a plan versus subsequent years (c.f., *renewal year*) that a beneficiary remains enrolled in a plan.

Like plan type means one of the following:

(i) PDP replaced with another PDP.

(ii) MA or MA-PD replaced with another MA or MA-PD.

(iii) Cost plan replaced with another cost plan.

Plan year and *enrollment year* mean the year beginning January 1 and ending December 31.

Renewal year means all years following the initial enrollment year in the same plan or in different plan that is a like plan type.

Unlike plan type means one of the following:

(i) An MA or, MA-PD plan to a PDP or Section 1876 Cost Plan.

(ii) A PDP to a Section 1876 Cost Plan or an MA or MA-PD plan.

(iii) A Section 1876 Cost Plan to an MA or MA-PD plan or PDP.

(b) ***Agent/broker requirements.*** Agents and brokers who represent MA organizations must follow the requirements in paragraphs (b)(1) through (3) of this section. Representation includes selling products (including Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Medicare Prescription Drug plans, and section 1876 Cost plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries.

(1) Be licensed and appointed under State law (if required under applicable State law).

(2) Be trained and tested annually as required under paragraph (c)(4) of this section, and achieve an 85 percent or higher on all forms of testing.

(3) Secure and document a Scope of Appointment prior to meeting with potential enrollees.

(c) ***MA organization oversight.*** MA organizations must oversee first tier, downstream, and related entities that represent the MA organization to ensure agents and brokers abide by all applicable State and Federal laws, regulations, and requirements. MA organizations must do all of the following:

(1) As required under applicable State law, employ as marketing representatives only individuals who are licensed by the State to conduct marketing (as defined in this subpart) of health insurance in that State, and whom the MA organization has informed that State it has appointed, consistent with the appointment process for agents and brokers provided for under State law.

(2) As required under applicable State law, report the termination of an agent or broker to the State and the reason for termination.

(3) Report to CMS all enrollments made by unlicensed agents or brokers and for-cause terminations of agents or brokers.

(4) On an annual basis, provide training and testing to agents and brokers on Medicare rules and regulations, the plan products that agents and brokers will sell, including any details specific to each plan product, and relevant State and Federal requirements.

(5) On an annual basis by the last Friday in July, report to CMS whether the MA organization intends to use employed, captive, or independent agents or brokers in the upcoming plan year and the specific rates or range of rates the plan will pay independent agents and brokers. Following the reporting deadline, MA organizations may not change their decisions related to agent or broker type, or their compensation rates and ranges, until the next plan year.

(6) On an annual basis by October 1, have in place full compensation structures for the following plan year. The structure must include details on compensation dissemination, including specifying payment amounts for initial enrollment year and renewal year compensation.

(7) Submit agent or broker marketing materials to CMS through HPMS prior to use, following the requirements for marketing materials in this subpart.

(8) Ensure beneficiaries are not charged marketing consulting fees when considering enrollment in MA plans.

(9) Establish and maintain a system for confirming that:

(i) Beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan.

(ii) Agents and brokers appropriately complete Scope of Appointment records for all marketing appointments (including telephonic and walk-in).

(10) Demonstrate that marketing resources are allocated to marketing to the disabled Medicare population as well as to Medicare beneficiaries age 65 and over.

(11) Must comply with State requests for information about the performance of a licensed agent or broker as part of a state investigation into the individual's conduct. CMS will establish and maintain a memorandum of understanding (MOU) to share compliance and oversight information with States that agree to the MOU.

(d) ***Compensation requirements.*** MA organizations must ensure they meet the requirements in paragraphs (d)(1) through (5) of this section in order to pay compensation. These compensation requirements only apply to independent agents and brokers.

(1) ***General rules.***

(i) MA organizations may only pay agents or brokers who meet the requirements in paragraph (b) of this section.

(ii) MA organizations may determine, through their contracts, the amount of compensation to be paid, provided it does not exceed limitations outlined in this section.

(iii) MA organizations may determine their payment schedule (for example, monthly or quarterly). Payments (including payments for AEP enrollments) must be made during the year of the beneficiary's enrollment.

(iv) MA organizations may only pay compensation for the number of months a member is enrolled.

(2) ***Initial enrollment year compensation.*** For each enrollment in an initial enrollment year, MA organizations may pay compensation at or below FMV.

(i) MA organizations may pay either a full or pro-rated initial enrollment year compensation for:

(A) A beneficiary's first year of enrollment in any plan; or

(B) A beneficiary's move from an employer group plan to a non-employer group plan (either within the same parent organization or between parent organizations).

(ii) MA organizations must pay pro-rated initial enrollment year compensation for:

(A) A beneficiary's plan change(s) during their initial enrollment year.

(B) A beneficiary's selection of an “unlike plan type” change. In that case, the new plan would only pay the months that the beneficiary is enrolled, and the previous plan would recoup the months that the beneficiary was not in the plan.

(3) ***Renewal compensation.*** For each enrollment in a renewal year, MA plans may pay compensation at an amount up to 50 percent of FMV.

(i) MA plans may pay compensation for a renewal year:

(A) In any year following the initial enrollment year the beneficiary remains in the same plan; or

(B) When a beneficiary enrolls in a new "like plan type".

(ii) [Reserved]

(4) ***Other compensation scenarios.***

(i) When a beneficiary enrolls in an MA-PD, MA organizations may pay only the MA compensation (and not compensation for Part D enrollment under § 423.2274 of this chapter).

(ii) When a beneficiary enrolls in both a section 1876 Cost Plan and a stand-alone PDP, the 1876 Cost Plan sponsor may pay compensation for the cost plan enrollment and the Part D sponsor must pay compensation for the Part D enrollment.

(iii) When a beneficiary enrolls in a MA-only plan and a PDP plan, the MA plan sponsor may pay for the MA plan enrollment and the Part D plan may pay for the PDP plan enrollment.

(iv) When a beneficiary changes from two plans (for example, a MA plan and a stand-alone PDP) (dual enrollments) to one plan (MA-PD), the MA organization may only pay compensation at the renewal rate for the MA-PD product.

(5) ***Additional compensation, payment, and compensation recovery requirements (Charge-backs).***

(i) MA organizations must retroactively pay or recoup funds for retroactive beneficiary changes for the current and previous calendar years. MA organizations may choose to recoup or pay compensation for years prior to the previous calendar year, but they must do both (recoup amounts owed and pay amounts due) during the same year.

(ii) Compensation recovery is required when:

(A) A beneficiary makes any plan change (regardless of the parent organization) within the first three months of enrollment (known as rapid disenrollment), except as provided in paragraph (d)(5)(iii) of this section.

(B) Any other time period a beneficiary is not enrolled in a plan, but the plan paid compensation based on that time period.

(iii) Rapid disenrollment compensation recovery does not apply when:

(A) A beneficiary enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.

(B) A beneficiary's enrollment change is not in the best interests of the Medicare program, including for the following reasons:

(*1*) Other creditable coverage (for example, an employer plan).

(*2*) Moving into or out of an institution.

(*3*) Gain or loss of employer/union sponsored coverage.

(*4*) Plan termination, non-renewal, or CMS imposed sanction.

(*5*) To coordinate with Part D enrollment periods or the State Pharmaceutical Assistance Program.

(*6*) Becoming LIS or dually eligible for Medicare and Medicaid.

(*7*) Qualifying for another plan based on special needs.

(*8*) Due to an auto, facilitated, or passive enrollment.

(*9*) Death.

(*10*) Moving out of the service area.

(*11*) Non-payment of premium.

(*12*) Loss of entitlement or retroactive notice of entitlement.

(*13*) Moving into a 5-star plan.

(*14*) Moving from an LPI plan into a plan with three or more stars.

(iv)

(A) When rapid disenrollment compensation recovery applies, the entire compensation must be recovered.

(B) For other compensation recovery, plans must recover a pro-rated amount of compensation (whether paid for an initial enrollment year or renewal year) from an agent or broker equal to the number of months not enrolled.

(*1*) If a plan has paid full initial compensation, and the enrollee disenrolls prior to the end of the enrollment year, the total number of months not enrolled (including months prior to the effective date of enrollment) must be recovered from the agent or broker.

(*2*) Example: A beneficiary enrolls upon turning 65 effective April 1 and disenrolls September 30 of the same year. The plan paid full initial enrollment year compensation. Recovery is equal to 6/12ths of the initial enrollment year compensation (for January through March and October through December).

(e) ***Payments other than compensation (administrative payments).***

(1) Payments made for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace.

(2) Administrative payments can be based on enrollment provided payments are at or below the value of those services in the marketplace.

(f) ***Payments for referrals.*** Payments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries) to an agent, broker or other entity for potential enrollment into a plan. The payment may not exceed $100 for a referral into an MA or MA-PD plan and $25 for a referral into a PDP plan.

(g) ***TPMO oversight.*** In addition to any applicable FDR requirements under § 422.504(i), when doing business with a TPMO, either directly or indirectly through a downstream entity, MA plans must implement the following as a part of their oversight of TPMOs:

(1) When a TPMO is not otherwise an FDR, the MA organization is responsible for ensuring that the TPMO adheres to any requirements that apply to the MA plan.

(2) Contracts, written arrangements, and agreements between the TPMO and an MA plan, or between the TPMO and an MA plan's FDR, must ensure the TPMO:

(i) Discloses to the MA organization any subcontracted relationships used for marketing, lead generation, and enrollment.

(ii) Records all calls with beneficiaries in their entirety, including the enrollment process.

(iii) Reports to plans monthly any staff disciplinary actions or violations of any requirements that apply to the MA plan associated with beneficiary interaction to the plan.

(iv) Uses the TPMO disclaimer as required under § 422.2267(e)(41).

(3) Ensure that the TPMO, when conducting lead generating activities, either directly or indirectly for an MA organization, must, when applicable:

(i) Disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:

(A) Verbally when communicating with a beneficiary through telephone.

(B) In writing when communicating with a beneficiary through mail or other paper.

(C) Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.

(ii) Disclose to the beneficiary that he or she is being transferred to a licensed agent who can enroll him or her into a new plan.

[86 FR 6112, Jan. 19, 2021, as amended at 87 FR 27899, May 9, 2022]

§ 422.2276 Employer group retiree marketing.

MA organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the MA organization, and furnish these materials only to the group members. These materials are not subject to CMS prior review and approval.

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

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CalAIM Dual Eligible Special Needs Plans Policy Guide

August 2022

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Introduction

This California Advancing and Innovating Medi-Cal initiative (CalAIM) Dual Eligible Special Needs Plan (D-SNP) Policy Guide is intended to serve as a resource for D-SNPs in California, including both exclusively aligned enrollment (EAE) D-SNPs and non-EAE D-SNPs.

D-SNPs are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal, and offer care coordination and wrap-around services. All D-SNPs in California must have executed contracts with the Department of Health Care Services (DHCS), the state Medicaid agency. These contracts, referred to as the State Medicaid Agency Contract (SMAC) or Medicare Improvements for Patients and Providers Act (MIPPA) contract, must meet a number of requirements, including Medicare-Medicaid integration requirements. DHCS developed two SMAC templates for 2023: the first for EAE-SNPs and the second for non-EAE D-SNPs. DHCS maintains the authority to contract or not to contract with D-SNPs.

As part of the CalAIM initiative, DHCS is leveraging the lessons and success of the Cal MediConnect (CMC) Financial Alignment Initiative to launch EAE D-SNPs, effective January 1, 2023, in the seven counties where the Coordinated Care Initiative (CCI) was implemented: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. EAE D-SNPs are D-SNPs where enrollment is limited to D-SNP members who are also enrolled in the affiliated Medi-Cal managed care plan.

This CalAIM D-SNP Policy Guide is intended to serve as a resource for all D-SNPs, beginning in Contract Year (CY) 2023, by providing additional details to supplement the 2023 SMAC. The Policy Guide provisions that apply to all D-SNPs, and those that apply only to EAE D-SNPs, are indicated at the beginning of each section. The provisions of this Policy Guide will be part of the DHCS SMAC requirements for 2023. Updates will be published as guidance is added.

Summary of Updates and Key Changes

Date	Chapter/Section	Update/Change	Notes
8/19/22	IV. Enrollment and Disenrollment	• Initial Release	
8/19/22	VI. Quality and Reporting Requirements	• Initial Release	
8/19/22	VII. Integrated Materials	• Initial Release	
6/30/22	I. Care Coordination	• Specified language regarding training content for dementia care specialists	
6/30/22	Appendix A	• Revised formatting of LTSS questions for HRA	
6/9/22	I. Care Coordination	• Updated language regarding training content for dementia care specialists • Added language regarding ECM benefit for Duals	
6/9/22	V. Continuity of Care	• Initial Release	
12/30/21	I. Care Coordination	• Initial Release	

I. Care Coordination Requirements

The purpose of this section is to provide state-specific care coordination requirements to health plans intending to operate EAE D-SNPs in California, beginning January 1, 2023. These requirements are specific to EAE D-SNPs, however non-EAE D-SNPs are welcome to adopt this approach.

The state requirements described in this section are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual. They are similar to requirements included in the CMC three-way contract, and will be included in California's SMAC for EAE D-SNPs in 2023. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

New EAE D-SNPs must reflect these state requirements in their Model of Care narratives for 2023, using the provided CalAIM EAE D-SNP components template (Appendix C). Existing D-SNPs, that will become EAE D-SNPs in 2023, which are not required to resubmit their Models of Care in February 2022 for CY 2023, should consider whether an off-cycle Model of Care update would be needed to accurately reflect their care coordination process as a result of implementing the state requirements. All EAE D-SNPs should submit their Models of Care to DHCS by 8pm Pacific Time on February 16, 2022, on a file and use basis. Should DHCS identify any concerns with a plan's Model of Care, the department will contact the plan for further information.

Risk Stratification

D-SNP risk stratification of enrollees must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of:

- Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization) and utilization data from the member's CMC plan (for members transitioning from the CMC to the D-SNP in 2023);
- Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data;
- The results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs), if available; and
- Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).

Additional technical guidance on how to access Medi-Cal data not otherwise available from the aligned Medi-Cal managed care plan will be forthcoming.

Health Risk Assessment (HRA)

To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long as the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance.

D-SNPs must ensure their HRA identifies the following elements:

(1) Medi-Cal services the member currently accesses.
(2) Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation of the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order.
(3) Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease.

If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.

Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs)

Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities.

The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance.

The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to:

- Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations)
- County mental health and substance use disorder services
- Housing and homelessness providers
- Community Supports (formerly ILOS) providers in the aligned MCP network
- 1915(c) waiver programs, including MSSP
- LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
- Medi-Cal transportation to access Medicare and Medi-Cal services

D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports.

Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers. D-SNPs should leverage available training content from community-based organizations with expertise in serving people with dementia when developing training content for dementia care specialists.

These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.

Care Transitions

D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.

Medi-Cal Enhanced Care Management (ECM) and Dual Eligible Beneficiaries

From January 2022 to July 2024, DHCS will implement the Medi-Cal ECM requirement for MCPs throughout the state. DHCS' requirements for MCPs to implement ECM are contained in the CalAIM ECM Policy Guide, ECM and ILOS Contract Template (ECM and ILOS Contract A), which will become part of the MCPs' contract with DHCS, and the DHCS' ECM and ILOS Standard Provider Terms and Conditions. The Medi-Cal ECM benefit represents an opportunity for MCPs to work with providers, counties and community-based organizations (CBOs) to deliver a strong set of integrated supports for those who need them most, including dual eligible beneficiaries.

Some EAE D-SNP members needing care management services through EAE D-SNPs may also meet the criteria for ECM populations of focus. However, there is significant overlap across the D-SNP model of care and ECM requirements, which could result in duplication and confusion for members and care teams if a member receives care management from both programs. Since member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs, DHCS intends for EAE D-SNPs to provide sufficient care management to members so that those members that would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP. For 2023, DHCS guidance for EAE D-SNPs is to provide integrated care management across Medicare and Medi-Cal benefits with the intent that beneficiaries will receive any ECM-like services they may need through the D-SNP. For members already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing ECM providers when possible, until the member graduates from ECM.

<table>
<tr><th></th><th>2022</th><th>2023</th><th>2024</th></tr>
<tr><td>Most Dual Eligible MCP Enrollees
In MA or Medicare FFS</td><td colspan="3">• ECM provided by their MCP
• Member must meet Population of Focus (POF) requirements</td></tr>
<tr><td>Non-EAE D-SNP Enrollees</td><td>• Same as above</td><td>• Same as above</td><td rowspan="2">• ECM-like care management provided through D-SNP
• Requirements to be outlined in D-SNP Policy Guide</td></tr>
<tr><td>EAE D-SNP Enrollees</td><td>• ECM-like care management provided by Cal MediConnect Plan</td><td>• ECM-like care management provided by EAE D-SNP</td></tr>
</table>

II. Information Sharing Policy (coming in 2022)

III. Network Guidance for EAE D-SNPs (coming in 2022)

IV. Enrollment and Disenrollment

D-SNP shall implement and maintain procedures to ensure that all Members requesting enrollment, disenrollment, or information regarding the disenrollment process are provided relevant information about their choices and Medicare rules and that their enrollment choices are appropriately processed. D-SNPs must adhere to all existing Medicare and Medi-Cal rules on noticing; these are additional scenarios that apply to the new EAE environment.

Special Enrollment Periods

1. The intent of this language is to help ensure that members are able to disenroll from a D-SNP and enroll in another Medicare Advantage plan using the same Special Enrollment Period (SEP).

    a. D-SNP must inform Members about the rules guiding Medicare SEPs if they request disenrollment, including any information they may need to appropriately execute enrollment into another Medicare Advantage plan.
        i. Beneficiaries should be encouraged to proactively enroll in the plan of their choice, during a valid period, which will automatically disenroll them from their current plan.
        ii. This will avoid confusion related to returning to fee-for-service Medicare, potentially needing to wait three months to join a new Medicare Advantage plan, or any Part D issues that would arise when disenrolling through their current plan directly.

MMP and Medicare Eligibility

1. Eligibility Age
    a. EAE D-SNPs may only enroll beneficiaries 21 years of age or older.
2. In cases where a member loses Medicare eligibility but remains in the Medi-Cal Managed Care Plan, the D-SNP must send a disenrollment notice.

V. Medicare Continuity of Care Guidance for All D-SNPs

The purpose of this section is to provide state-specific Medicare continuity of care requirements to dual eligible special needs plans (D-SNPs) in California, beginning January 1, 2023. These requirements are in addition to any existing federal Medicare Advantage (MA) requirements. These requirements are in accordance with Assembly Bill 133 (Chapter 143, Statutes of 2021), the Health Omnibus Budget Trailer Bill, Welfare and Institutions Code Section 14184.208:

> "(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders."

The intent of these state-specific Medicare continuity of care requirements for D-SNPs is to ensure continued access to Medicare providers and covered services for members joining the D-SNP. These requirements are for Medicare providers and Medicare covered services and are similar to requirements included in the Cal MediConnect (CMC) three-way contract, and are included in California's State Medicaid Agency Contract (SMAC) for all D-SNPs in 2023.

Continuity of care requirements for Medi-Cal providers and Medi-Cal covered services can be found in All Plan Letter 18-008.

Additional network requirements are covered in the Network Guidance chapter of this policy guide. The network requirements are designed to ensure overall network adequacy as well as to support continued access to existing providers for Medi-Cal only beneficiaries transitioning to dual eligible status and enrolling in a D-SNP.

Continuity of Care for Medicare Primary and Specialty Providers

Upon member request, or request by other authorized person as noted below, D-SNPs must offer continuity of care with out-of-network Medicare providers to all members if all of the following circumstances exist:

- A member has an existing relationship with a primary or specialty care provider. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of their initial enrollment in the D-SNP for a non-emergency visit;
- The provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule, as applicable; and
- The provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

If the member leaves the D-SNP and later rejoins the D-SNP, then the D-SNP must offer the member a 12-month continuity of care period based on the date of re-enrollment, regardless of whether the member received continuity of care in the past. If a member changes D-SNPs, the continuity of care period may start over one time. If the member

changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the member a new 12-month period.

Requirements Regarding Primary Care Providers and Delegated Entities

When a member transitions into a D-SNP, and has an existing relationship with a PCP that is in the D-SNP's network, as determined through 1) the HRA process; 2) review of prior utilization data; or 3) member request, the D-SNP must assign the member to the PCP, unless the member chooses a different PCP. If the D-SNP contracts with delegated entities, it must assign the member to a delegated entity that has the member's preferred PCP in its network.

When a member transitions into a D-SNP, has an existing relationship with a PCP and at least one specialist that is in the D-SNP's network, and the member wishes to continue to seek treatment from each of these providers, the D-SNP must allow the member to continue treatment with each of these providers for the continuity of care period. This is regardless of whether these providers are, or are not, in the network of the primary plan's delegated entity to which the member is assigned, as long as the continuity of care requirements are met.

For example, if a member has an existing relationship with a PCP and a specialist with the assigned Independent Physicians Association #1 (IPA #1) as well as a specialist in another IPA (IPA #2), where both IPAs are delegated entities of the same D-SNP, the D-SNP must assign the member to IPA #1 and allow the member to continue treatment with both specialists. The continuity of care agreement for the specialist in IPA #2 would last for up to 12 months.

D-SNPs are required to notify their delegated entities of these requirements and the delegated entities are also required to provide continuity of care to their assigned members.

Procedures for Requesting Continuity of Care

Members, their authorized representatives, or their providers, may make a direct request to a D-SNP for continuity of care. Only those providers who treat members who are eligible for continuity of care, as noted above, may make a request to the D-SNP for continuity of care.

D-SNPs must, at a minimum, accept requests for continuity of care over the telephone, according to the requestor's preference, and cannot require the requester to complete and submit a paper or computer form. To complete a telephone request, the D-SNP may take any necessary information from the requester over the telephone.

D-SNPs must accept and approve retroactive requests for continuity of care and pay claims that meet all continuity of care requirements noted above, with the exception of the requirement to abide by the D-SNP's utilization management policies. The services that are the subject of the request must have occurred after the member's enrollment into the D-SNP, and the D-SNP may require the member, their authorized representative, or their provider to demonstrate that there was an existing relationship between the member and

provider prior to the member's enrollment into the D-SNP. D-SNPs must approve any retroactive requests that:

- Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
- Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted.

The D-SNP must accept retroactive requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare Fee-for-Service (FFS) claim), an MA plan, another D-SNP, or the primary plan instead of the delegate.

When a request for continuity of care is made, the D-SNP must process the request within five working days after receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. The continuity of care process begins when the D-SNP starts the process to determine if there is a pre-existing relationship and enters into an agreement with the provider.

A member or their provider may provide information to the D-SNP that demonstrates a pre-existing relationship with a provider. A member or provider may not attest to a pre-existing relationship (instead, actual documentation must be provided) unless the D-SNP makes this option available to them.

Following identification of a pre-existing relationship, the D-SNP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other form of agreement in order to establish a continuity of care relationship for the member.

Request Completion Timeline

Each continuity of care request must be completed within:

- 30 calendar days from the date the D-SNP receives the request;
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- The member is informed of their right to continued access or if the D-SNP and the out-of-network provider are unable to agree to terms;
- The D-SNP has documented quality of care issues with the provider; or
- The D-SNP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Requirements after the Request Process is Completed

If a D-SNP and the out-of-network FFS or prior plan provider are unable to reach an agreement because they cannot agree to terms or a reimbursement rate, or the D-SNP has documented quality of care issues with the provider, the D-SNP must offer the member an in-network alternative. If the member does not make a choice, the member will be assigned to an in-network provider. Members maintain the right to pursue an appeal or grievance through the Medicare process.

If an out-of-network provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement, or other form of agreement with the D-SNP, the D-SNP must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the D-SNP for a shorter timeframe. In this case, the D-SNP must allow the member to have access to that provider for the shorter period of time.

At any time, a member may change providers regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the D-SNP must work with the out-of-network provider to establish a care plan for the member.

Upon completion of a continuity of care request, D-SNPs must notify members of the following within seven calendar days:

- The request approval or denial, and if denied, the member's appeal and grievance rights;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the D-SNP's provider network.

D-SNPs must also notify members 30 calendar days before the end of the continuity of care period about the process that will occur to transition the member's care at the end of the continuity of care period. This process must include engaging with the member and out-of-network provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

D-SNP Extended Continuity of Care Option

D-SNPs may choose to work with a member's out-of-network provider past the continuity of care period, but D-SNPs are not required to do so.

Continuity of Care for Medicare Durable Medical Equipment and Medical Supply Providers

Additionally, D-SNPs must ensure members have access to medically necessary Medicare-covered Durable Medical Equipment (DME) and medical supplies. In addition to complying with Medicare continuity of care requirements for these services and providers as outlined in 42 CFR 422.100(l)(2)(iii), D-SNPs must comply with the following requirements.

- Members joining a D-SNP with existing DME rentals must be allowed to keep their existing rental equipment until the D-SNP can evaluate the member, equipment is in the possession of the member, and ready for use.
    - After 90 days (per 42 CFR 422.100(l)(2)(iii)) and when the D-SNP is able to reassess the member, and, if medically necessary, authorize a new rental and have an in-network provider deliver the medically necessary rental.
- Members joining a D-SNP that have an open authorization to receive Medicare-covered medical supplies may continue to use their existing provider:
    - For 90 days per 42 CFR 422.100(l)(2)(iii); and
    - Until the D-SNP is able to reassess the member, and, if medically necessary, authorize supplies and have an in-network provider deliver the medically necessary supplies.

Member and Provider Outreach and Education

D-SNPs must inform members, or their authorized representatives, of continuity of care protections within 30 days of enrollment, and must include information about these protections in member information materials and handbooks. This information must include how a member and provider initiate a continuity of care request with the D-SNP. These documents must be translated into threshold languages and must be made available in alternative formats in compliance with Medi-Cal requirements, currently in APL 21-0004. D-SNPs must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

VI. Quality and Reporting Requirements

The purpose of this section is to provide state-specific Medicare and Medi-Cal quality and reporting requirement metrics to EAE and non-EAE D-SNPs in California, beginning January 1, 2023. These requirements are in addition to existing federal MA requirements.

Background

State-specific reporting requirements for EAE D-SNPs are part of a larger quality strategy within DHCS, including a focus on the Comprehensive Quality Strategy focused on dual eligible individuals, the Long-Term Services and Supports (LTSS) dashboard, and the Master Plan for Aging.

D-SNPs have robust reporting requirements for both Medi-Cal and Medicare. DHCS monitors the quality of care and health equity provided to members in Medi-Cal through various reporting requirements, as detailed in the 2022 DHCS Comprehensive Quality Strategy and Medi-Cal contracts.

DHCS built upon promising practices and quality reporting metrics from Cal MediConnect (CMC) plans, particularly as statewide and plan-specific performance has been a helpful benchmark to evaluate members' experiences in CMC plans.

In developing the state-specific quality and reporting requirements for EAE D-SNPs, DHCS considered:

1) Overall quality and integrated care goals for D-SNPs.
2) Clinical value, and alignment with Medicare and Medi-Cal goals and measures.
3) Existing data sent to CMS that DHCS can receive.
4) Existing DHCS data that can be analyzed.
5) CMC measures to maintain for initial enrollment transition monitoring.

DHCS may require EAE and non-EAE D-SNPs to report all Medicare quality data reported to CMS on an annual basis at the Plan Benefit Package (PBP) level.

State-Specific Quality and Reporting Requirements

In addition to all federally required reporting requirements, EAE D-SNPs must submit the following measures to the state at the PBP level. D-SNPs must submit the data to DHCS according to the reporting schedule listed below in an SFTP determined by the state. D-SNPs must internally validate all data and quality measures submitted to DHCS. Additionally, for the Healthcare Effectiveness Data and Information Set (HEDIS) measures listed below, the D-SNP performance rates must be certified by an external entity (e.g., the National Committee for Quality Assurance, NCQA) prior to submission to DHCS.

When available, D-SNPs must consult the data measure steward for any technical questions (e.g., the NCQA for HEDIS measures).

Please see below for a list of the state-specific quality and reporting requirements.

Access/Availability of Care

I. HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)

II. HEDIS Controlling High Blood Pressure (CBP)[1]

Effectiveness of Care

III. HEDIS Poor HbA1c Control (>9.0%) (CDC-H9)[1]

IV. HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Utilization and Risk Adjusted Utilization

V. HEDIS Plan All-Cause Readmissions (PCR)

Care Coordination

VI. Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)

VII. Members with an Individualized Care Plan (ICP) Completed (CA 1.5)

VIII. Members with Documented Discussions of Care Goals (CA 1.6)

Organizational Structure and Staffing

IX. Care Coordinator to Member Ratio (Core 5.1)

X. Care Coordinator Training for Supporting Self-Direction (CA 3.2)

Medi-Cal Long-Term Services and Supports

XI. Community-Based Adult Services (CBAS)

XII. In-Home Supportive Services (IHSS)

XIII. Multipurpose Senior Services Program (MSSP)

XIV. Long-Term Care (LTC)

[1] Measures selected for race/ethnicity stratification by NCQA. D-SNP plans will be required to report race/ethnicity stratifications, per HEDIS General Guidelines, to DHCS.

Alzheimer's/Dementia Quality of Care

XV. Cognitive Health Assessment

State-Specific Guidance for Quality Measures

HEDIS Measures (I, II, III, IV, V):

- EAE and non-EAE D-SNPs must prepare and submit certified state-specific and D-SNP-specific HEDIS measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. Regular MA results should be excluded if the plan has both regular MA and D-SNP PBPs.
- For CBP and CDC-H9, D-SNP plans will be required to report race/ethnicity stratifications, per HEDIS General Guidelines.
- HEDIS measures should be submitted annually to DHCS, based on the submission schedule provided by HEDIS.
- Plans should refer to "HEDIS Volume 2: Technical Specifications for Health Plans" for detailed information on complete technical specifications for each measure.
- Note: The target population for each HEDIS measure should be EAE and non-EAE D-SNP members at the PBP level.

Medicare-Medicaid Plan (MMP) Core Reporting Requirements (VI and IX)

- EAE and non-EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP specific CMC measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. Regular MA results should be excluded, if the plan has both regular MA and D-SNP PBPs.
- Core measure 3.2 must be reported on a quarterly basis to DHCS based on the reporting frequency for the ongoing reporting phase (not implementation phase). Care plans and care plan completeness should be defined as written in Core Measure 3.2 supporting materials.
- Core measure 5.1 must be reported on an annual basis to DHCS based on the reporting frequency for the ongoing reporting phase (not implementation phase).

MMP California-Specific Reporting Requirements (VII, VIII, X)

- EAE and non-EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP specific CMC measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has

both. Regular MA results should be excluded if the plan has both regular MA and D-SNP PBPs.

- CA 1.5 and 1.6 must be reported on a quarterly basis to DHCS based on the reporting frequency for the ongoing reporting phase (not implementation phase).
- CA 3.2 must be reported on an annual basis to DHCS based on the reporting frequency for the ongoing reporting phase (not implementation phase). Care plans.

Medi-Cal Long Term Services and Supports (XI, XII, XIII, XIV)

- EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP specific CMC measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results, if the organization has both. Regular MA results should be excluded, if the plan has both regular MA and D-SNP PBPs.
- Medi-Cal long-term services and supports measures must be reported on a quarterly basis to DHCS based on the reporting frequency for the ongoing reporting phase (not implementation phase).

New Alzheimer's/Dementia Quality of Care Measure (XV): Annual Cognitive Health Assessment for Patients 65 years and Older

- In recognition of the significant prevalence of Alzheimer's and related dementias among dually eligible beneficiaries, and the Department's Dementia Aware initiative, DHCS will require plans to report this measure. Similar to other measures, this should be reported to DHCS fully validated and at a state-specific and D-SNP specific level, with EAE D-SNP results separate from non-EAE D-SNP results, if the organization has both. Regular MA results should be excluded, if the plan has both regular MA and D-SNP PBPs.
- This measure should be reported on an annual basis to DHCS, for the reporting period January 1, 2023 to December 31, 2023, no later than June 1, 2024.

Additional detail and reference materials for each measure is provided below.

I. HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/
- The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.
- D-SNP members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

II. HEDIS Controlling High Blood Pressure (CBP)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/
- Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

III. HEDIS Comprehensive Diabetes Care (CDC) – HbA1c Poor Control (>9.0%)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
- Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each HbA1c poor control (>9.0%).

IV. HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/
- Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness. Two rates are reported:
    - ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
    - ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

V. HEDIS Plan All-Cause Readmissions (PCR)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/
- Assesses the rate of adult acute inpatient and observation stays that were followed by unplanned acute readmission for any diagnosis within 30 days after discharge among commercial (18 to 64), Medicaid (18 to 64), and Medicare (18 and older) health plan members. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. A separate readmission rate for hospital stays discharged to a skilled nursing facility among members aged 65 and older reported for Medicare plans. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across all health plans to produce a risk-standardized rate which allows for national comparison.

VI. Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)

- Additional information from CMS: https://www.cms.gov/files/document/mmpcorereportingreqscy2022.pdf, https://www.cms.gov/files/document/coremeasure32faqs.pdf

A. Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.

B. Of the total reported in A, the number of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.

C. Of the total reported in A, the number of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment. Three outreach attempts must be clearly documented.

D. Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment. Completed care plans must be clearly documented.

E. Percentage members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment. Percentage = (B / A) * 100

F. Percentage of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment. Percentage = (C / A) * 100

G. Percentage of members who had a care plan completed within 90 days of enrollment. Percentage = (D / A) * 100

H. Percentage of members who were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment. Percentage = (D / (A – B – C)) * 100

VII. Members with an Individualized Care Plan (ICP) Completed (CA 1.5)

- Additional information from CMS: https://www.cms.gov/files/document/careportingrequirements02282022.pdf-0

A. Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.

B. Of the total reported in A, the number of high-risk members who had an initial ICP completed as of the end of the reporting period.

C. Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period.

D. Of the total reported in C, the number of low-risk members who had an initial ICP completed as of the end of the reporting period.

E. Percentage of high-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period. Percentage = (B / A) * 100

F. Percentage of low-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period.

VIII. Members with Documented Discussions of Care Goals (CA 1.6)

- Additional information from CMS: https://www.cms.gov/files/document/careportingrequirements02282022.pdf-0

A. Total number of members with an initial ICP completed during the reporting period.

B. Of the total reported in A, the number of members sampled that met inclusion criteria.

C. Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP.

D. Total number of existing ICPs revised during the reporting period.

E. Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.

F. Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals.

G. Percentage of members with an initial ICP completed during the reporting period who had evidence of creation of at least one care goal documented in the initial ICP. Percentage = (C / B) * 100

H. Percentage of existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals. Percentage = (F / E) * 100

IX. Care Coordinator to Member Ratio (Core 5.1)

- Additional information from CMS: https://www.cms.gov/files/document/mmpcorereportingreqscy2022.pdf.

A. Total number of FTE care coordinators working on the Demonstration as of the last day of the reporting period.

B. Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.

C. Total number of FTE care coordinators that left the MMP during the reporting period.

D. Number of members per FTE care coordinator. Rate = (Total Members Enrolled / A)

E. Percentage of FTE care coordinators who were assigned to care management and conducting assessments. Percentage = (B / A) * 100

F. Percentage of FTE care coordinators that left the MMP during the reporting period. Percentage = (C / (C + A)) * 100

X. Care Coordinator Training for Supporting Self-Direction (CA 3.2)

- Additional information from CMS: https://www.cms.gov/files/document/careportingrequirements02282022.pdf-0.

A. Total number of full-time and part-time care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.

B. Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction under the demonstration within the reporting period.

C. Percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period. Percentage = (B / A) * 100

XI. Community-Based Adult Services (CBAS)

A. Enter the total number of members currently receiving services during the reporting quarter.

B. Total number of referrals made for CBAS services for the reporting period.

C. Total number of initial member assessments completed by the CBAS centers for the reporting quarter. CBAS Eligibility Determination Tools (CEDTs) do not qualify as an initial assessment and should not be included.

D. Enter the total number of initial members approved for services for the reporting period.

E. Enter the total number of member reassessments completed by the MMP for the reporting period. Per Medi-Cal Managed Care boilerplate contract requirements (Exhibit A, Attachment 19), beneficiaries are required to be reassessed every six months to determine their eligibility for CBAS services.

F. Enter the total number of member reassessments that were approved by the MMP for the reporting quarter.

G. Enter the total number of members denied for CBAS services for the reporting quarter. Select only one of the 5 denial options for each member denial (Not Medically Necessary, Incomplete Assessment, Member Refused Service, Transition to Other Program or Setting, Other Reason).

XII. In-Home Supportive Services (IHSS)

A. Enter the total number of ICTs w/ county social worker (county DPSS liaison) participation for the reporting quarter.

B. Enter the number of members referred to county for IHSS for the reporting period.

C. Enter the total number of member referrals received for IHSS for the reporting quarter.

XIII. Multipurpose Senior Services Program (MSSP)

A. Total number of ICTs w/ MSSP Care Manager participation for the reporting period.

B. Total number of members receiving MSSP during the reporting period.

C. Total number of member referrals made for MSSP for the reporting period.

XIV. Long-Term Care (LTC)

A. Total number of members currently residing in LTC for >90 days during the reporting period.

B. Total number of member referrals received for LTC stays >90 days the reporting quarter. This column is for members being referred to LTC for a stay anticipated to be >90 days for the first time during the reporting period.

C. Enter the total number of initial member assessments for LTC stay >90 days completed for the reporting quarter. This column is for members being assessed for LTC for the first time during the reporting period.

D. Total number of members initially approved for LTC stay >90 days for the reporting quarter. This column is for members being approved for LTC stay for the first time during the reporting period.

E. Total number of members reassessed for LTC stay >90 days for the reporting quarter. This column is for members being reassessed for LTC for the first time during the reporting period.

F. Total number of member reassessment approved for LTC stay >90 days for the reporting quarter. This column is for members being reapproved for LTC stay for the first time during the reporting period.

G. Total number of members denied for LTC services for the reporting quarter. Use only one of the 5 denial options for each member denial (Not Medically Necessary, Incomplete Assessment, Member Refused Service, Transition to Other Program or Setting, Other Reason).

XV. Annual Cognitive Assessment for Patients 65 Years and Older

- Additional information from the American Academy of Neurology (page 8): https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality-measures/2019.03.25-mci-measures.pdf.

A. Percentage of patients aged 65 and older who had cognition assessed within the measurement period.

VII. Integrated Materials for EAE D-SNPs

The purpose of this section is to provide state-specific integrated Member materials requirements for exclusively aligned enrollment (EAE) dual eligible special needs plans (D-SNPs) in California. The state requirements described in this section are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V and as described in the Medicare Communications and Marketing Guidelines (MCMG)[2]. These requirements are also included in California's SMAC for EAE D-SNPs in 2023.

EAE D-SNPs are responsible for providing integrated materials to Members. Required integrated Member materials include:

- Annual Notice of Change (ANOC)
- ANOC Coversheet
- Member Handbook/Evidence of Coverage (EOC)
- Summary of Benefits
- Member Identification (ID) Card
- Provider/Pharmacy Directory
- List of Covered Drugs (Formulary)

Integrated appeals and grievances materials will be detailed in a separate D-SNP policy guide chapter.

Program Name
The California-specific program name for EAE D-SNPs is Medicare Medi-Cal Plans (MMPs or Medi-Medi plans). The goal of this branded program name is to describe the type of plan and differentiate EAE D-SNPs from Medi-Cal plans, regular Medicare Advantage plans, unaligned D-SNPs, or PACE products. DHCS will also use this name for Health Care Options (HCO) and on the DHCS website. Though not required, DHCS recommends plans leverage the following naming convention:

First reference in each section or chapter: <Mandatory Plan Name> (Plan Type), a Medicare Medi-Cal Plan

Provider Directory
Plans must comply with existing federal and state guidelines regulating print and online provider directories. DHCS expects that print and online directories for EAE D-SNPs will reflect all contracted and in-network providers for D-SNP members, effective January 1, 2023, and be updated regularly through December 31, 2023. The intent of the provider directories is to show the providers that are in the D-SNP Medicare and/or Medi-Cal

[2] See https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.

networks in a clear manner for D-SNP members. Plans are not required to indicate whether the provider is contracted on the D-SNP or Medi-Cal side, to avoid member confusion.

Translation

EAE D-SNPs are required to make all integrated materials available in the threshold languages for their aligned managed care plan (MCP) Service Area. Threshold languages are defined as those languages that meet the more stringent of either:

- Medicare's five percent (5%) threshold for language translation[3]; or
- DHCS' prevalent language requirements (the DHCS threshold and concentration standard languages), as specified in annual guidance to Contractors on specific translation requirements for their Service Areas, currently found in APL 21-004.

EAE D-SNPs must have a process for ensuring that enrollees can make a standing request to receive materials in alternate formats and in all non-English languages, at the time of request and on an ongoing basis thereafter. The process should include how the plan will keep a record of the member's information and utilize it as an ongoing standing request so the member does not need to make a separate request for each material and how a member can change a standing request for preferred language and/or format. EAE D-SNPs may refer to Cal MediConnect marketing guidance for additional instruction on material formats and translations.

Submission and Review Process

DHCS will release templates for the required integrated Member materials to all EAE D-SNP plans in Q2, annually. In addition to the Integrated Member Materials, plans will receive the Department of Managed Health Care's (DMHC) filing checklist that includes the requirements for the filing that must be submitted to the DMHC.

Upon completing the templates, EAE D-SNPs are required to submit their completed integrated material templates to DMHC and DHCS for review and approval by close of business on the dates listed below. Plans must simultaneously submit their completed materials to DMHC through the DMHC portal and to the DHCS inbox 2PlanDeliverables@dhcs.ca.gov. The filings/submissions should include clean and redlined copies of each document. Plans should direct questions relating to DMHC materials approval to the assigned licensing reviewer. Note: The processes may change for CY2024 materials.

The Provider/Pharmacy Directory should be submitted with variable language populated, however it is not necessary for provider and pharmacy content to be added at the point of submission.

[3] Pursuant to 42 C.F.R. §§ 422.2268(a)(7) and 423.2268(a)(7), Medicare Part C plans and Part D sponsors (Sponsors) are required to translate vital materials into any non-English language that is the primary language of at least five (5) percent of the individuals in a plan benefit package (PBP) service area. The Sponsors that have service areas that meet the five (5) percent threshold must provide these translated materials on their websites and in hardcopy upon beneficiary request.

After approval from both DHCS and DMHC, the ANOC, Member Handbook/EOC, and Summary of Benefits should be submitted as file and use in HPMS a minimum of five (5) days prior to their use as described at 42 CFR section 422.2261(b)(3). The Member ID Card, Formulary, and Provider/Pharmacy Directory will not need to uploaded to HPMS.

Beneficiary Material	Deadline to Submit to DHCS and DMHC	Estimated State Approval Date	Date Materials to be Uploaded to HPMS	Due to Current Enrollees
Annual Notice of Change (ANOC)	July 20, 2022	August 31, 2022	September 30, 2022	September 30, 2022
Member Handbook/ Evidence of Coverage (EOC)	July 21, 2022	September 9, 2022	October 15, 2022	October 15, 2022
Summary of Benefits	August 1, 2022	August 31, 2022	October 15, 2022	October 15, 2022
Member ID Card	August 1, 2022	August 31, 2022	N/A	Within 10 days of when plan receives enrollment in their system (early November 2022)
Formulary	August 1, 2022	August 31, 2022	N/A	October 15, 2022
Provider and Pharmacy Directory	August 1, 2022	August 31, 2022	N/A	October 15, 2022

VIII. Appendices

Appendix A: LTSS Questions for Inclusion in EAE D-SNP HRA

The questions are organized in the following two tiers and EAE D-SNPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

- Tier 1 contains questions directly related to LTSS eligibility criteria, and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in bold are not part of the questions, but provide the intent of the questions.

Tier 1 LTSS Questions:
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living

Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action)
a) Taking a bath or shower
b) Going up stairs
c) Eating
d) Getting Dressed
e) Brushing teeth, brushing hair, shaving
f) Making meals or cooking
g) Getting out of a bed or a chair
h) Shopping and getting food
i) Using the toilet
j) Walking
k) Washing dishes or clothes
l) Writing checks or keeping track of money
m) Getting a ride to the doctor or to see your friends
n) Doing house or yard work
o) Going out to visit family or friends
p) Using the phone
q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?

Housing Environment / Functional Supports (Social Determinants Risk Factor)
Question 2: Can you live safely and move easily around in your home? (Yes/No)
If no, does the place where you live have: (Yes/No to each individual item)
a) Good lighting
b) Good heating
c) Good cooling
d) Rails for any stairs or ramps
e) Hot water
f) Indoor toilet
g) A door to the outside that locks
h) Stairs to get into your home or stairs inside your home
i) Elevator
j) Space to use a wheelchair
k) Clear ways to exit your home

Low Health Literacy (Social Determinants Risk Factor)
Question 3: “I would like to ask you about how you think you are managing your health conditions”
a) Do you need help taking your medicines? (Yes/No)
b) Do you need help filling out health forms? (Yes/No)
c) Do you need help answering questions during a doctor’s visit? (Yes/No)

Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family members or others willing and able to help you when you need it? (Yes/No)

Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)

Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No)
Question 6b: Is anyone using your money without your ok? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (Yes/No)
Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one)
None – I never feel lonely
Less than 5 days
More than half the days (more than 15)
Most days – I always feel lonely

Appendix B: 2023 CalAIM EAE D-SNP Components Template

Please complete and submit this document with the 2023 EAE D-SNP Model of Care to your DHCS contract manager by 8pm Pacific Time on February 16, 2022

Applicant's Contract Name (as provided in HPMS):	
Applicant's CMS Contract Number:	

DHCS issued state-specific care coordination requirements to health plans intending to operate EAE D-SNPs in California, beginning January 1, 2023 through the D-SNP Policy Guide, December 2021

The state requirements described in the policy guide are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual.

Please populate the table below to indicate the location of the state-specific requirements in the 2023 D-SNP Model of Care.

MOC 2: Care Coordination	
Requirement	**Corresponding Document Section and Page Number**
Risk Stratification D-SNP risk stratification of enrollees must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of: • Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization) and utilization data from the member's CMC plan (for members transitioning from the CMC to the D-SNP in 2023); • Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data; • The results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs), if available; and • Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).	

Health Risk Assessment (HRA) To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance. D-SNPs must ensure their HRA identifies the following elements: 1. Medi-Cal services the member currently accesses. 2. Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation on the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order. 3. Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease. If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.	
Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs) Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities. The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-	

Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal edicar e guidance for ICPs conflict, plans should follow edicare guidance. The ICP must identify any carved-out services the member and how the D -SNP will facilitate access and document ferrals (including at least three (3) outreach attempts), cludin g but not limited to referrals and connections to: Community Based Organizations such as those erving members with disabilities (e.g. independent iving centers) and those s erving members with dementia (e.g. Alzheimer's organizations) County mental health and substance use disorder services Housing and homelessness providers Enhanced Care Management (ECM) and Community Supports (formerly ILOS) providers in he aligned MCP net work 1915(c) waiver programs, including MSSP LTSS programs, including IHSS and Community-Based Adult Services (CBAS) Medi-Cal transportation to access Medicare and Medi-Cal services -SNP care coordinators/managers participating in the ICT ust be trained by the plan to identify and understand the full pectrum of Medicare and Medi -Cal LTSS programs, including e- and community-based services and long-term nstitutional care. The ICT should include pr oviders of any Medi-al services the member is receivi ng, including LTSS and ommunity Supports. Irrespective of having a formal Alzheimer's or dementia agnosis, if the member has documented dementia care , including but not limited to: w andering, home safety oncer ns, poor self-care, behavioral issues, issues with edication adherence, poor compliance with management of -existing conditions, and/or inability to manage ADLs/IADLS, he ICT must include the member's caregiver and a trained entia care specialist to the extent possible and as nsiste nt with the member's preferences. Dementia care pecialists must be trained in: un derstanding Alzheimer's isease and Related Dementias (ADRD); symptoms and ogression; understanding and managing behav iors and ommunica tion problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees	

and caregivers. These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.	
Care Transitions D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.	

Medicare Communications and Marketing Guidelines (MCMG)

Date: 02/09/2022

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Introduction

The Medicare Advantage (MA) and Part D Marketing and Communications (MCMG) provides the marketing and communications requirements for Medicare Advantage (MA) plans, section 1876 cost plans, and Medicare Prescription Drug Plans (collectively referred to as "plans") governed under Title 42 of the Code of Federal Regulations (CFR), Parts 417, 422, and 423. These requirements also apply to Medicare-Medicaid Plans (MMPs), except as modified in state-specific marketing guidance for each state's demonstration. State-specific guidance for MMPs is considered an addendum to the regulations and MCMG, and is generally posted at the Medicare-Medicaid Plan (MMP) Marketing Information & Resource page on CMS.gov. The MCCG has been structured to align with the regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. The MCMG should be used in conjunction with the regulatory requirements to aid plans in understanding and complying with the regulations.

Compliance
Plans are responsible for ensuring compliance with applicable Federal laws and regulations, including CMS' marketing and communications regulations. This includes monitoring and overseeing the activities of their subcontractors, downstream entities, and/or delegated entities. Failure to comply with applicable rules may result in compliance and/or enforcement actions, including, but not limited to, intermediate sanctions and/or civil money penalties.

Note: Plans may impose additional restrictions on their subcontractors, downstream entities, and/or delegated entities, provided they do not conflict with the requirements outlined in regulations or the MCMG.

Definitions (42 CFR §§ 422.2260, 423.2260)

Communications means activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their caregivers, are "communications" within the scope of the regulations at 42 CFR Parts 417, 422, and 423.

Note: Where the term enrollee is used, whether a current or prospective enrollee, the term encompasses representatives of the enrollee who are authorized to act on the enrollee's behalf.

Marketing is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon.

Intent

Material or activities that CMS determines, as described above, are intended to:

- Draw a beneficiary's attention to a plan or plans,
- Influence a beneficiary's decision-making process when making a plan selection, or
- Influence a beneficiary's decision to stay enrolled in a plan (retention-based marketing).

Content

Materials or activities that include or address content regarding:

- The plan's benefits, benefits structure, premiums, or cost sharing,
- Measuring or ranking standards (for example, Star Ratings or plan comparisons), or
- Rewards and incentives as defined under 42 CFR § 422.134(a) (for MA and section 1876 cost plans only).

Below are examples to assist in identifying marketing versus communication.

1. A flyer reads "Swell Health is now offering Medicare Advantage coverage in Nowhere County. Call us at 1-800-BE-SWELL for more information."
   Marketing or Communication? Communication. While the intent is to draw a beneficiary's attention to Swell Health, there is no marketing content.

2. A billboard reads "Swell Health Offers $0 Premium Plans in Nowhere County"
   Marketing or Communication? Marketing. The advertisement includes both the intent to draw the viewer's attention to the plan and has content that mentions zero-dollar premiums being available.

3. A letter is sent to enrollees to remind them to get their flu shot. The body of the letter says, "Swell Health enrollees can get their flu shot for $0 copay at a network pharmacy…"
   Marketing or Communication? Communication. While the letter mentions cost sharing, the intent is not to steer the reader into selecting a plan or to stay with their current plan, but to encourage current enrollees to get a flu shot. The letter contains factual information and was provided only to current enrollees in the plan.

4. A third-party television commercial where an actor says: "Call us to hear about plans that can provide hearing and dental benefits, zero-dollar monthly premiums, and can even lower your Medicare Part B costs."
   Marketing or Communications? Marketing. While a specific plan is not mentioned by name, the commercial's intent is to draw the beneficiary to a MA plan or plans and the content addresses plan premium, cost-sharing, and benefit information for plans being represented and sold by the third party.

CMS's regulations at 42 CFR §§ 422.2267(e) and 423.2267(e) designate all required materials and content as either communications or marketing. Plans will need to review regulations at 42 CFR §§ 422.2260 and 423.2260 and these guidelines to determine if a "Plan-Created Material" (i.e., something not listed as a required material in 42 CFR §§ 422.2267(e) and 423.2267(e)) is considered a communication or marketing material. Plans are also encouraged to consult with their Regional Office Account Manager or Marketing Reviewer about any marketing or communications questions.

Materials are static in nature, whereas activities are more dynamic. Interactions with a beneficiary could begin as a communication activity but become a marketing activity. For example, an enrollee calls the plan's customer service number for questions related to coverage under the plan in which in the caller is currently enrolled; during the call, the enrollee asks about other health plan options, moving the call from communications to marketing. The plan must comply with all applicable requirements during communications and marketing activities. In cases where an interaction transitions from a communication activity to a marketing activity, the plan must comply with all applicable requirements for each type of activity during the relevant portion of the interaction.

Other Definitions

Age-ins - An individual who is aging into Medicare eligibility. Such individuals typically elect to enroll in a plan during the seven-month period consisting of three months before they turn age 65, the month they turn 65, and the three months after they turn 65.

Co-Branding - A relationship between two or more separate legal entities, where at least one party is a plan. Co-branding is when a plan displays the name(s) or brand(s) of the co-branding entity or entities on its materials to signify a business arrangement. Co-branding relationships are independent of the contract that the plan has with CMS. Plans are responsible for ensuring that co-branded materials include appropriate disclaimers and other model content as specified by CMS regulations at 42 CFR §§ 422.2267(e)(36) and 423.2267(e)(37) where applicable.

CMS Required Materials – Materials that are required under 42 CFR §§ 422.2267(e) and 423.2267(e)

Plan Created Materials – Materials created by plans, typically advertisements, that are not required under 42 CFR §§ 422.2267(e) and 423.2267(e).

Submission, Review, and Distribution of Materials (42 CFR §§ 422.2261, 423.2261)

§§ 422.2261(a), 423.2261(a) - General requirements

- ***All marketing*** materials, election forms, and certain designated communications materials used by a plan, including those used by third-party and downstream entities, must be submitted to CMS for review.

§§ 422.2261(a)(1), 423.2261(a)(1) – The HPMS Marketing Module is the primary system of record for the collection, review, and storage of materials that must be submitted for CMS review

- In limited situations and with prior approval from CMS, plans may submit materials outside of HPMS.
- **Non-English/Alternate Format Materials**
    - Plans are not required to submit non-English language materials that are translations of a previously submitted English version. The English Version of the Standardized material identification (SMID) may be used on non-English translations.
    - If a plan creates a material to be used only in a non-English language, the plan must submit an English translation to HPMS via a zip file containing both the material and the translations.
    - Plans are not required to submit alternate format versions of a previously submitted standard material.

- **Submission of Required Websites** –Websites that plans are required to maintain pursuant to 42 CFR §§ 422.2265 and 423.2265 do not require submission if they are limited to only providing the content and materials required under 42 CFR §§ 422.2265(b), 423.2265(b), 422.2265(c), and 423.2265(c). Required websites that contain additional marketing content must be submitted to CMS on an annual basis (contract year). Submission is done by selecting "Plan Required Website" under the "CMS Required" section of the HPMS Marketing Module. Regardless of submission, websites must include the current Material ID on all web pages. The following outlines how applicable websites must be submitted.

    - Each Contract Year's initial website submission must use a Microsoft Word document (or similar) listing the items on the website and must contain the website's URL. Screenshots, test sites, etc. are not needed. The Standardized Material Identification (SMID) used for the submission must correspond to the material ID on the website, except it will end with an underscore followed by the contract year (e.g., H1234_abcwebsite_M_2022). The contract year is not required on the actual webpages.
    - Updates made to the website for the same contract year, must be submitted using a Microsoft Word document (or similar) containing the URL and a list of all changes. The same material ID on the site's pages are permitted (e.g. H1234_abcwebsite_M). However, updated submissions must use the website's material ID followed by an underscore and contract year, followed by an underscore and a letter ("A", "B", "C", etc.) corresponding to each

resubmission (e.g., H1234_abcwebsite_M_2020_A). The contract year and the letter do not have to be shown on the actual website.

- Plans are not required to submit web page updates when only communication content or content required in 42 CFR §§ 422.2265, 423.2265 has been updated.
- As outlined under §§ 422.2261(b)(3) and 423.2261(b)(3), plans must wait five (5) days following the submission of a website or website change(s) before going live with the website. However, plans are not required to take down their website while they are making updates.

§§ 422.2261(a)(3), 423.2261(a)(3) – Third-party submissions

Consultant Submitted Multi-Plan Marketing Materials - CMS permits third parties to submit marketing materials directly to CMS, on behalf of contracted plans, when the marketing materials created by a third party include marketing content of and used by multiple (two or more) plans. For example, if the third party operates a website that lists all contracted plans and their cost sharing, and is used by beneficiaries to select and enroll into a plan, the third party may submit the website on behalf of the contracted plans.

Note: The multi-plan submission process is intended for third parties that submit for multiple organizations. If the third party's marketing materials only mention one organization, then the plan should submit the material directly to CMS using the standard submission process.

Providing Consultant Access – The following steps are for third-party access to the HPMS marketing module for multi-plan submissions.

- Prepare an official letter that states the user's name, CMS user ID, consultant company name, the type of consultant access being requested, and the contract/multi-contract entity (MCE) number(s) for which consultant access is needed. The letter must be provided on the organization's official letterhead and signed by a senior official of the organization. Organizations can submit one letter and include multiple consultants on that letter if they are all obtaining the same consulting access type. CMS recommends the use of the following sample language:

  (Name of organization) hereby requests that (name of consultant user, the CMS user ID, and consultant company name) be granted Marketing Consultant Access for Multi-Plan Submissions for the following contract number(s): (list specific contract numbers or provide the MCE number).
- Submit the official letter via e-mail in scanned PDF format to HPMSConsultantAccess@cms.hhs.gov. To facilitate timely processing, please indicate the type of consultant access in the subject line of the e-mail. It is a best practice for the plan to cc the third-party for which they are requesting access.
- An email confirmation will be provided to all included in the original e-mail (sender and all cc'd) when access has been granted. Unless the third-party was cc'd on the original e-mail request, plans are responsible for informing the third-party that the access has been approved.
- It is important to note that consultant user access is limited in HPMS to only the multi-plan portion of the marketing module. Third parties cannot see or access other plan

related marketing information outside of multi-plan submissions.
- For more information, please refer to the May 26, 2021 HPMS memo, "Updated - Instructions for Requesting Consultant Access to the Health Plan Management System (HPMS)."

Note: Ultimately, it is the responsibility of the plan to manage and maintain the set of users for whom they have authorized access to HPMS. User access can be viewed under the "User Resources > User Access Administration" link in HPMS. If a user within an organization does not currently have access to the "plan user access" reports, organizations must submit a request to hpms_access@cms.hhs.gov.

Multi-Plan Submission Process – Third-party Perspective – Once consultant access has been granted to the third party by at least one contract/MCE, the third party may begin submitting multi-plan marketing materials. The following applies to multi-plan submitted materials:

- The submissions process is the same as the plan submissions process (i.e. collection of marketing content, audience, life cycle, media types, etc.), however, multi-plan submissions can only be made for Plan Created Materials
- During the initial submission process, the third party is able to select from any contracts/MCEs who have authorized access
- The third-party will select a reviewer from a list of multi-plan dedicated CMS reviewers
- Review timeframes are the same as they would be for plan submitted materials (e.g., 45-day or file and use ("F&U"))
- After the material has been approved (or accepted for F&U submissions), all plans whose contract/MCE was selected as a part of the submission will be notified (no plan notification is provided up until this point)
- Upon receipt of the email, plans whose contract/MCE was selected must "Opt-In" or "Opt-Out" of the material
- The third-party may not use the material for an associated contract/MCE unless the plan has opted-in
- HPMS sends an e-mail to the third-party for all submission updates, including when each plan provides an "Opt-In" or "Opt-Out"
- A plan opting in or out of a material does not impact the material's review status (i.e. approved or accepted)
- The third-party can add additional contracts/MCEs after the material has been approved
- The third-party will see a "tab" for each contract/MCE that is associated with the material (plans are only able to see their own "tab")

Note: Please refer to §§ 422.2262(d) and 423.2262(d) for SMID requirements for multi-plan materials.

Multi-Plan Submission Process – Plan Perspective – After the plan grants access to the marketing module for multi-plan submissions, the following happens after a material has been submitted for the plan's contract/MCE and approved (or accepted for F&U) <OR> when a plan's contract/MCE number has been added to an already approved material:

- The plan will receive an email from HPMS notifying the plan that a multi-plan material has been submitted that includes their contract/MCE number.

- Upon receipt of the email, the plan should review the material and "opt-in" or "opt-out".
    - "Opting-In" – indicates that the plan is aware of the material and is providing their concurrence that they will be associated with the submission (i.e. that the material will be used by the third-party for the contract/MCE noted)
    - "Opting-Out" – indicates that the plan does not want to be associated with the submission (i.e. that the material will not be used by the third-party for the contract/MCE noted)
    - Opting-in/out does not impact the status of the material in HPMS (e.g., it will remain approved/accepted)
- Plans are responsible for the content of multi-plan materials they have opted into and responsible for ensuring the materials remain compliant with the most current requirements. *See* 42 CFR §§ 422.503(b)(4)(vi), 422.504(i), 423.504(b)(4)(vi), 423.505(i).

Note: The expectation is that all conversations and external reviews of the material have already occurred prior to the material being submitted into HPMS. The multi-plan submission process is not the vehicle for plan review of third-party submitted materials.

§§ 422.2261(b)(3), 423.2261(b)(3) – File and Use (F&U)

CMS designates certain marketing materials as F&U eligible based on the material's content, audience, and intended use, as they apply to potential risk to the beneficiary. A material submitted under F&U may be used five days following its submission, provided the plan certifies the material complies with all applicable standards.

- The "Marketing Lookups" function in the HPMS Marketing Module identifies what materials (for CMS Required Materials) and what media types (for Plan Created Materials) qualify for F&U submissions. Plans without an executed contract may submit F&U materials. However, once the contract is executed, CMS presumes that the plan has, by submission of the materials, attested that the material complies with all requirements regardless if the materials were submitted before or after contract execution.
- Plans may be subject to compliance actions if:
    - Materials are used before they are "accepted" (i.e. five days following the submission of the material), or
    - Materials are found during a CMS review to be out of compliance with the applicable requirements under §§422.2260 through 422.2267 and §§ 423.2260 through 423.2267.

§§ 422.2261(d), 423.2261(d) – Standards for CMS Review

- **Placeholders (formerly "template materials")** –CMS permits the use of placeholders to represent certain variable data in required or Plan Created Materials (except for SBs, as provided in Appendix 2). Variable data fields for premiums, cost sharing, benefits should only be used when the document is applicable for more than one plan. The type of data that will populate the placeholder dictates how the material is submitted.
    - Plans have the choice on whether to use placeholders. If a plan does not want to

use placeholders the data in the submitted materials must be bracketed (e.g., [$10 Copay/$15 Copay/$20 Copay]). If the plans are using placeholders, the plan must include the data type in brackets along with a reference to where the data can be found in the spreadsheet or table (e.g. [Copay, see column "A"]). The submission for materials with placeholders consists of a zipped file which contains the material and a spreadsheet or table identifying the actual data for each variable field. Spreadsheets or tables must only include the variable data found in the submitted material for the contracts/plans associated with the submitted material.

- When using placeholders that include non-marketing content, the content can be represented in the material by the data type in brackets (e.g. [date], [hours of operation], [agent name]). In this instance, a table containing the actual data is not required with the submission, however, such data must be made available upon request.

- **Remedying a previously disapproved material** - Plans should clearly indicate all changes/updates when resubmitting materials that were previously disapproved, such as highlighting text changes or inserting notes or identifying changes in the comments section.
- **Material Replacement** - For the specified materials below, HPMS now has a "material replacement" functionality to allow updated materials to be resubmitted as a replacement file attachment using the same SMID. Material replacement is available for:
    - Annual Notice of Change (ANOC)
    - Summary of Benefits (SB)
    - Evidence of Coverage (EOC)
    - Star Ratings Document
    - Sales scripts and presentations
    - Enrollment scripts
    - Enrollment forms (online and paper)

  If the material replacement function is used, do not mark the original material as "no longer in use."

  The material replacement function is not available for previously submitted materials other than those listed above; any other materials that require changes/updates must be marked as "no longer in use" and resubmitted with a new SMID.
- **Updates to CMS Required Materials -** Plans must review all required documents for accuracy and resubmit if changes or corrections to previously submitted CMS Required Materials are identified (e.g., the benefit or cost-sharing information differs from that in the approved bid). In addition, the following requirements apply:
    - ANOC, EOC, and formulary errata must be sent in hard copy within a reasonable timeframe or electronically if the enrollee has opted into receiving electronic versions, and
    - SB addenda or reprints must be sent only to existing enrollees if the plan mass mailed the SB.

General Communications Materials and Activities Requirements (42 CFR §§ 422.2262, 423.2262)

§§ 422.2262(a) 423.2262(a) - General rules

- To avoid misleading or confusing beneficiaries, plans must make it clear when an encounter with a beneficiary is moving from a communications activity to a marketing activity, such as when a beneficiary is being transferred to a sales or enrollment representative. Before transferring, the beneficiary must clearly consent to being transferred.

§§ 422.2262(a)(1)(x), 423.2262(a)(1)(x) – Plan type in plan name

- When a plan's communications activities or materials include the plan name, the plan type must also be included. The plan is not required to repeat the plan type when the plan name is used multiple times in the material, but should include the plan type, at the end of the plan name, when the plan name is first mentioned or in a way that prominently conveys the plan type to the recipient.

General Marketing Requirements (42 CFR §§ 422.2263, 423.2263)

§§ 422.2263(b)(2), 423.2263(b)(2) – Nominal gifts

CMS's regulations governing marketing prohibit plans from offering gifts to beneficiaries unless the gifts are of nominal value. The regulations refer to guidance published by the HHS Office of Inspector General (HHS OIG) for the meaning of "nominal value." HHS OIG's current interpretation of "nominal value" is set forth in "Office of Inspector General's (OIG's) Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries," and is no more than $15 per item or $75 in the aggregate, per person, per year. CMS' interpretation of the terms "nominal gifts" and "cash equivalents," as described below, is intended to align with HHS OIG's interpretations of the same (or in the case of "nominal gifts," similar) terms.

The following rules apply to nominal gifts:

- Nominal gifts must be offered to similarly situated beneficiaries without discrimination and without regard to whether the beneficiary enrolls in a plan.
- Nominal gifts may not be in the form of cash, including cash-equivalents, or other monetary rebates.
- CMS is adopting OIG's interpretation of cash equivalents. OIG has interpreted the term "cash equivalents" to encompass items convertible to cash (such as a check) or items that can be used like cash (such as a general-purpose debit card, but not a gift card that can be redeemed only for certain categories of items or services, like a fuel-only gift card redeemable at gas stations). See 85 Fed. Reg. 77,684, 77,789-90 (Dec. 2, 2020), 81 Fed. Reg. 88,368, 88,393 n. 19 (Dec. 7, 2016). CMS's interpretation of "cash equivalents" for the purposes of this regulation mirrors OIG's interpretation subject to the following, additional guidance.
    - A general gift card that is not restricted to specific retail chains or to specific items and categories would fall under those types that would be considered a cash equivalent (e.g. Visa gift card).
    - Gift cards for retailers or online vendors that sell a wide variety of consumer

products would also fall under this prohibition (e.g., Walmart and Amazon).
    - A gift card that can be used for a more limited selection of items or food, would not be considered a cash equivalent (e.g. Starbucks or a Shell Gas gift card).

§§ 422.2263(b)(3), 423.2263(b)(3) – Exclusion of meals as a nominal gift

- Refreshments and light snacks are not considered "meals." Plans should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal.
- Meals may be provided at educational events that meet CMS's regulations and other events that would fall under the definition of communications.

§§ 422.2263(b)(7), 423.2263(b)(7) – Prohibition of marketing during the Open Enrollment Period (OEP)

- The term "knowingly", as used in the regulation, considers the recipient and content of the message. For example, if messaging specifically calling out the OEP is sent, it would be knowingly targeting. Likewise, if a plan was aware that an individual had already made an AEP enrollment decision, sending unsolicited marketing materials to that individual, even if the OEP was not mentioned, would be considered "knowingly targeting."
- The requirement does not restrict a plan from:
    - Providing educational materials or marketing materials if and when the beneficiary proactively reaches out looking for OEP help. Providing marketing materials and other information in response to a request from a beneficiary is at the beneficiary's request and hence not unsolicited.
    - Marketing to dual-eligible and LIS beneficiaries who, in general, may make changes at least once per calendar quarter during the first nine (9) months of the year.
    - Marketing from 5-Star plans, as individuals can enroll into the 5-Star plan at any time using the 5 Star SEP.
    - Using mailings or other marketing aimed at individuals aging into the Medicare program unless the plan knows the individual has already made an enrollment decision. For example, a plan buys a list of age-ins and sends marketing mailers to all addressing their newly eligible Medicare status. Since the plan has no way to know if any of these age-ins already selected a plan it is not considered knowingly targeting during the OEP, provided the content of the message is about their Initial Coverage Election Period and does not address or include any references to the OEP.
    - Including educational information, excluding marketing, on the plan's website about the existence of OEP.
- Marketing messages aimed at generating interest or leads during the OEP are generally prohibited, unless as noted above. For example, a generic marketing line of "not happy with your plan, change now" would be considered inappropriate marketing.

Beneficiary Contact (42 CFR §§ 422.2264, 423.2264)

§§ 422.2264(a)(2)(i), 423.2264(a)(2)(i) – Prohibition on the use of door to door solicitation

- Agents/brokers who have a pre-scheduled appointment with a potential enrollee who is a "no-show" may leave information at that enrollee's residence.

§§ 422.2264(a)(2)(iv), 423.2264(a)(2)(iv) - Telephone solicitation

- Other types of electronic direct messaging, such as through social media analogous to text messaging are not permitted.
- Text messages regarding care and care coordination are permissible with prior current enrollee consent. An opt-out process must be included on each communication.

§§ 422.2264(b), 423.2264(b) - Contact for plan business

- Plans may not market prior to October 1 (§§ 422.2263(a) and 423.2263(a)) under the pretext of plan business.
- CMS provides Medicare beneficiary data to plans for the purpose of enrolling, disenrolling, and providing care to members in their plan. The permitted uses of data provided by CMS are outlined in the data use agreement signed by plans.

§§ 422.2264(c), 423.2264(c) - Events with beneficiaries

- As established under §§ 422.62(a)(2)(iii) and 423.38(b)(3), the annual coordinated election period for the following calendar year is October 15 through December 7. As such, enrollment applications may not be solicited or accepted for a January 1 effective date until October 15 of the preceding calendar year, unless the beneficiary has an SEP.

Note: Plans are reminded that other laws – such as the HIPAA privacy rules - may limit the use of information gathered from other sources or in connection with other products offered by the plan. Nothing in this guidance creates an exemption or exception to other applicable laws.

Websites (§§ 422.2265, 423.2265)

As required under §§ 422.111(h)(2), 422.2265, 423.128(d)(2), and 423.2265, all plans must have a website that includes specific documents and content. The following operational guidance should be used in conjunction with the regulatory requirements, with an emphasis on those requirements found under §§ 422.2265 and 423.2265.

Note: This guidance only pertains to plan required websites.

§§ 422.2265(a), 423.2265(a) - General website requirements

- Notification must be provided when beneficiary leaves the plan's Medicare information website, noting that the individual will go to non-Medicare information website or to a different website.
- Websites must comply with anti-discrimination provisions, such as Section 508 of the Rehabilitation Act, with regard to providing access to websites and other materials. See also 45 CFR § 92.104.

§§ 422.2265(b), 423.2265(b) – Required content

- CMS considers it a best practice to provide instructions on how to appoint a representative and a link to the downloadable version of the CMS Appointment of Representative Form (CMS Form-1696)
- To ensure that eligible beneficiaries are able to enroll without restriction, CMS also considers it a best practice for plans to provide enrollment instructions and forms
- When providing required content regarding how to file a grievance (§§ 422.562(a)(2) and 423.562(a)(2)), request an organization determination, and an appeal, plans should include the following:
    - Written procedures for filing;
    - A direct link on the grievance/coverage determination webpage to the Medicare.gov complaint, where an enrollee can enter a complaint in lieu of calling 1-800-MEDICARE;
    - Phone number(s) for receiving oral requests;
    - Mailing address for written requests;
    - Fax number (optional);
    - Links, if applicable, to any forms created by the plan for appeals and grievances;
    - Information on how to obtain an aggregate number of grievances, appeals, and exceptions filed with the plan; and
    - Contact numbers for enrollees and/or physicians to use for process or status questions.

§§ 422.2265(c), 423.2265(c) - Required posted materials

- All required materials must be clearly labeled and easily found.
- Plans must include the last update date of the material, in close proximity to the material link (e.g. in file name, next to link, etc.) For example, a link that reads "Super MA Plan EOC, updated 11/23/2021."
- Updates (e.g., to correct an error) to materials must be posted as soon as possible.

Activities with Healthcare Providers or in the Healthcare Setting (42 CFR §§ 422.2266, 423.2266)

§§ 422.2266(c)(7), 423.2266(c)(7) – Announcing new or continuing affiliations

- Provider affiliation announcements made by plans that do not include marketing are considered communications. If the announcement contains marketing, the announcement must be submitted into HPMS.
- Provider affiliation announcements made by providers may not include marketing content. For example, an announcement that says Dr. Smith is now accepting Medicare Advantage X, and then provides cost sharing or other marketing content/intent (e.g. Plan X is the greatest Medicare Advantage Plan) would be prohibited.

Required materials and content (42 CFR §§ 422.2267, 423.2267)

Unless otherwise noted, the materials below designated as communications materials do not require HPMS submission.

§§ 422.2267(a)(2), 423.2267(a)(2) - For markets with a significant non-English speaking population

- ID cards are exempt from the translation requirements for markets with a significant non-English speaking population described at §§ 422.2267(a)(2) and 423.2267(a)(2).

§§ 422.2267(d)(1), 423.2267(d)(1) - When multiple enrollees are living in the same household

- When mailing materials to more than one individual living in the same household, the materials (e.g., envelope, cover letter) must clearly notate each individual name.
- Members in community residences (e.g., nursing facilities, group homes) must receive their own copy of non-beneficiary-specific materials, regardless of whether they have the same address.

§§ 422.2267(d)(2), 423.2267(d)(2) – When materials are delivered electronically

- Documents delivered electronically will be considered to be received by the enrollee as of the date the plan sends it; not when the enrollee opens/accesses it.

§§ 422.2267(d)(2)(i), 423.2267(d)(2)(i) – When materials are delivered electronically without prior authorization from the enrollee

- It is acceptable to state "currently available" if the documents have been posted prior to the notice.

§§ 422.2267(e), 423.2267(e) - CMS Required Materials and content
Unless otherwise noted, any CMS Required Material not listed below (or required under §§ 422.2267(b)(e) and 423.2267(b)(e)) are considered communications.

Plans may enclose additional benefit/plan operation materials with CMS Required Materials unless prohibited below or in instructions (e.g., ANOC instructions). These materials should be made distinct from the required material(s) and be related to the beneficiary's plan.

Annual Notice of Change (Marketing)

(42 CFR §§ 422.111(d)(2), 422.2267(e)(3), 422.2265(c)(1)(ii), 423.128(g)(2), 423.2267(e)(3), 423.2265(c)(1)(ii))

To Whom Required:	Provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
Timing:	• Must send for enrollee receipt no later than September 30 of each year. **Note**: ANOC must be posted on Plan/Part D website by October 15. • October 1, November 1, and December 1 enrollees must receive within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	File and Use. Must be submitted at least five days prior to mailing.
Format Specification:	Standardized Material.
Guidance and Other Relevant Information:	Marketing Models, Standard Documents, and Educational Material | CMS
Translation Required (5% Threshold):	Yes.

ANOC (Marketing) **and EOC** (Communications) **Errata**

(42 CFR §§ 422.2261, 422.2262, 423.2261, 423.2262)

To Whom Required:	Provided to current enrollees when errors are found in the ANOC or EOC.
Timing:	Must send to enrollees immediately following CMS approval.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	Where required, ANOC errata must be submitted by October 15, and EOC errata must be submitted by November 15.
Format Specification:	Standardized material.
Guidance and Other Relevant Information:	Refer to the annual Health Plan Management System memo "Issuance of Contract Year Model Materials" and "Contract Year Annual Notice of Change and Evidence of Coverage Submission Requirements and Yearly Assessment" memos.
Translation Required (5% Threshold):	Yes.

Comprehensive Medication Review Summary (Communication)
(42 CFR §§ 423.153(d)(1)(vii)(B) and (D))

To Whom Required:	Provided to enrollees in a plan's Medication Therapy Management (MTM) program after receiving a comprehensive medication review (CMR).
Timing:	May be provided to enrollee immediately following a CMR, or if distributed separately, materials should be sent out within 14 calendar days.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Standardized OMB-approved Format (Form CMS-10396, OMB Control Number 0938-1154). The Format cannot be modified, but the specific content to populate the Format must be tailored to address issues unique to the individual enrollee and may be customized for the Part D plan and MTM program.
Guidance and Other Needed Information:	See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM for • CMR Standardized Format and detailed implementation instructions, and • Annual MTM Program Submission Instructions memo. **Note**: MTM program materials should not include any marketing or promotional messages.
Translation Required (5% Threshold):	Yes.

Coverage/Organization Determination, Discharge, Appeals and Grievance Notices
(Communications) (42 CFR §§ 422.2267(e)(14) and (16)-(29), 423.2267(e)(18) and (20)-(31))

To Whom Required:	Provided to enrollees who have requested an appeal or have had an appeal requested on their behalf.
Timing:	Provided to enrollees on an ad hoc basis, based on required timeframes in 42 CFR Parts 422 and 423, subpart M.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Standardized OMB-approved denial notices for initial coverage denials (e.g. NDMCP); model notices for plan level appeals (Notice of Right to an Expedited Grievance).
Guidance and Other Relevant Information:	Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Medicare Managed Care Appeals & Grievances | CMS
Translation Required (5%	Yes.

Enrollment/Election Form/Request (Communications)
(Sections 1851(h)(1) and 1860D-01(b)(1)(vi) of the Social Security Act; 42 CFR §§ 422.60(c), 422.2267(e)(6); 423.32(b), 423.2267(e)(6))

To Whom Required:	Provided upon request.
Timing:	Not applicable.
Method of Delivery:	Paper enrollment forms may be in hard copy or electronic format (e.g., PDF file). Plans are permitted to send via email (when the beneficiary has authorized), online (e.g. portal) for current members (when the enrollee has authorized), and upon request (e.g., if beneficiary does not want to enroll telephonically or electronically).
HPMS:	Submission required by statute.
Format Specification:	Model Material. Must follow requirements for enrollment mechanisms and required data elements outlined in enrollment guidance.
Guidance and Other Relevant Information:	Eligibility, Enrollment, and Disenrollment – Medicare Managed Care Manual - Chapters 2 and 17d (collectively "Enrollment Guidance), and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
Translation Required (5% Threshold):	Yes.

Enrollment and Disenrollment Notices (Communications)
(42 CFR §§ 422.60(e)(3), 422.74(b), 422.2267(e)(7), 422.2267(e)(8), 423.32(d), 423.36(b)(2), 423.2267(e)(7), 423.2267(e)(8))

To Whom Required:	Provided as outlined in enrollment guidance.
Timing:	Must follow required timeframes as outlined in enrollment guidance.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material. Include elements as outlined in enrollment guidance.
Guidance and Other Relevant Information:	Eligibility, Enrollment, and Disenrollment – Medicare Managed Care Manuals: • Chapter 2 - Medicare Advantage Enrollment and Disenrollment • Chapter 17d - Subchapter D – Medicare Cost Plan Enrollment and Disenrollment Instructions Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
Translation Required (5% Threshold):	Yes.

Evidence of Coverage (Communications)
(42 CFR §§ 422.111(b), 422.2267(e)(1), 423.128(b,) 423.2267(e)(1))

To Whom Required:	Provided to all plan enrollees. October 1, November 1, and December 1 enrollees must receive the current EOC and the next calendar year EOC.
Timing:	• Provided to current plan enrollees by October 15 of each year. • Provided to new plan enrollees within 10 calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
Method of Delivery:	Hard copy, or electronically, as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	File and Use.
Format Specification:	Standardized Material
Guidance and Other Relevant Information:	No additional information.
Translation Required (5% Threshold):	Yes.

Excluded Provider Notice (Communications)
(42 CFR §§ 422.2267(e)(15), 423.2267(e)(19))

To Whom Required:	Provided to members who have used a provider who has been excluded from participating in the Medicare Program based on an OIG exclusion or the CMS preclusion list.
Timing:	Provided on an ad hoc basis.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Relevant Information:	Office of the Inspector General Exclusion Program
Translation Required (5% Threshold):	Yes.

Explanation of Benefits – Part C (Communications)
(42 CFR §§ 422.111(k), 422.2267(e)(2))

To Whom Required:	Provided to enrollees anytime a Part C benefit is utilized.
Timing:	Plan may send monthly or per claim with a quarterly summary.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR § 422.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Relevant Information:	Medicare Managed Care Manual, Chapter 4, Section 190.
Translation Required (5% Threshold):	Yes.

Explanation of Benefits – Part D (Communications)
(42 CFR §§ 423.2267(e)(2), 423.128(e))

To Whom Required:	Provided to enrollees anytime their prescription drug benefit is utilized.
Timing:	Must be provided by the end of month following the month when benefit was utilized.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Relevant Information:	Medicare Prescription Drug Manual Chapters 5 and 6.
Translation Required (5% Threshold):	Yes.

Formulary (Communications)
(42 CFR §§ 423.2267(e)(9), 423.128(b)(4))

To Whom Required:	Provided to all enrollees of plan.
Timing:	• Must be provided to current enrollees of plan by October 15 of each year. • Provide to new enrollees within 10 calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
Method of Delivery:	Hard copy, or electronically, as permitted in 42 CFR § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Relevant Information:	Refer to Part D Model Materials and Medicare Prescription Drug Benefit Manual, Chapter 6.
Translation Required (5% Threshold):	Yes.

Low Income Subsidy (LIS) Notice (Communications)
(42 CFR § 423.2267(c)(10))

To Whom Required:	Provided to potential enrollees once they are eligible for Extra Help and receive the low-income subsidy.
Timing:	Provided prior to effective date of enrollment.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Relevant Information:	Refer to Part D Model Materials
Translation Required (5% Threshold):	Yes.

Low Income Subsidy (LIS) Rider (Communications)
(42 CFR § 423.2267(e)(11))

To Whom Required:	Provided to all current enrollees who qualify for Extra Help.
Timing:	• Provided at least once per year by September 30. • Sent to enrollees who qualify for Extra Help or have a change in LIS levels within 30 days of receiving notification from CMS.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Relevant Information:	D-SNP enrollees who have $0 cost-sharing for all Part D drugs are exempt from sending a separate LIS Rider since the EOC's cost-sharing Information for drug copays is the same for everyone Medicare Prescription Drug Benefit Manual, Chapter 13, Section 70.2.
Translation Required (5% Threshold):	Yes.

Membership ID Cards (Communications)
(42 CFR §§ 417.427, 422.111(i), 423.120(c))

To Whom Required:	Provided to all plan enrollees.
Timing:	Provided to new enrollees within 10 calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later. Must also be provided to all enrollees if information on existing card changes.
Method of Delivery:	Provided in hard copy. In addition to the hard copy, plans may also provide a digital version (e.g., app).
HPMS:	Not applicable.
Format Specification:	Model material. Combination health and drug cards must follow the Workgroup for Electronic Data Interchange (WEDI) standards. Standalone Part D cards must follow the National Council for Prescription Drug Program (NCPDP) standards.
Guidance and Other Relevant Information:	• Cards must include Plan's/Part D sponsor's website address, customer service number, and contract/PBP number. • The front of the Part D sponsor card must include the Medicare Prescription Drug Benefit Program Mark. • PPO and PFFS ID cards must include the phrase "Medicare limiting charges apply." • May not use social security number (SSN).
Translation Required (5% Threshold):	No.

Mid-Year Change Notification to Enrollees (Communications)
(42 CFR §§ 422.2267(e)(9), 423.2267(e)(12), 423.120(b)(5))

To Whom Required:	Provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary.
Timing:	Ad hoc, based on specific requirements for each issue.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR §§ 422.2267(d) and 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model Material.
Guidance and Other Relevant Information:	• Notices of changes in plan rules unless otherwise addressed in regulation must be provided 30 days in advance. • National Coverage Determination (NCD) changes announced or finalized less than 30 days before effective date, notification required as soon as possible. • Mid-year NCD or legislative changes must be provided no later than 30 days after the NCD is announced or the legislative change is effective. • Plans may include change in next plan mass mailing (e.g., newsletter), provided it is within 30 days and must be reflected on Plan/Part D website. • Medicare Prescription Drug Benefit Manual - Chapter 6 for guidance related to midyear formulary changes and required notice. Updates to the chapter related to immediate generic substitutions consistent with 42 CFR 423.120(b)(5)(iv) are forthcoming. Sponsors should refer to the relevant regulation at 42 CFR 423.120(b)(5). • National Coverage Determination website.
Translation Required (5% Threshold):	Yes.

Non-Renewal Notices (Communication)
(42 CFR §§ 417.492(a)(ii) and (b)(ii), 422.74(d)(7), 422.506, 422.2267(e)(10), 423.44(d)(6), 423.507, 423.2267(e)(13))

To Whom Required:	Provided to enrollees affected by a non-renewal or service area reduction.
Timing:	At least 90 days before the end of the current contract year. Cost Plans, without Part D, at least 60 days before the end of the current contract year.
Method of Delivery:	Notices must be hard copy and sent via U.S. mail. First class postage is recommended.
HPMS:	Not applicable.
Format Specification:	Model material. - current contract year. Modifications permitted per instructions.
Guidance and Other Needed Information:	• Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until notice is received from CMS. • Plans may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the plan does business with (i.e., contracted providers). • Plans must provide a NR/SAR notice to beneficiaries who enroll in a non-renewing plan on October 1, November 1, or December 1 of the current contract year (e.g., less than 90 days before the effective date of the non-renewal). • Additional NR/SAR notice information can be found in the annual "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models" HPMS memo.
Translation Required (5% Threshold):	Yes.

Outbound Enrollment Verification (Communications)
(42 CFR §§ 422.2272(b), 423.2272(b))

To Whom Required:	Provided for all agent/broker assisted enrollments.
Timing:	Must be conducted within 15 calendar days following the receipt of the enrollment request.
Method of Delivery:	Hard copy, telephonic, email.
HPMS:	Not applicable.
Format Specification:	Model material. Must include required content.
Guidance and Other Needed Information:	• Communication must address enrollment into plan and provide customer service number for beneficiary questions regarding costs, benefits, rules, or any other question about plan. • May be completed via phone call (including during welcome call) or via email, if email is requested by an enrollee. • Must send a written communication if the plan fails to speak with the individual within 15 calendar days of enrollment requests. • Agent/brokers are not permitted to be part of the enrollment verification call. • Enrollment verification processes must stop if plan is notified that beneficiary is ineligible to enroll in plan or if beneficiary has canceled the enrollment. • Method and timing of the enrollment verification must be documented (date, time, and method of contact).
Translation Required (5% Threshold):	Yes.

Part D Transition Letter (Communications)
(42 CFR § 423.2267(e)(14))

To Whom Required:	Provided when a beneficiary receives a transition fill for a non-formulary drug.
Timing:	Sent within three (3) days of adjudication of temporary transition fill.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material. Modifications permitted.
Guidance and Other Needed Information:	Medicare Prescription Drug Benefit Manual Chapter 6, Section 30.4.10.

Pharmacy Directory (Communications)
(42 CFR §§ 423.128, 423.2267(e)(15))

To Whom Required:	Provided to all plan enrollees.
Timing:	• Provided to current plan enrollees by October 15 of the year prior to the applicable year. • Provided to new plan enrollees within 10 calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Part D plans must update pharmacy directory information any time they become aware of changes. All updates to the online provider directories must be completed within 30 days of receiving information requiring update. Updates to hardcopy provider directories must be completed within 30 days, however, hardcopy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery:	Hard copy, or electronically, as permitted in 42 CFR § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material. Current Contract Year Pharmacy Directory. Modifications permitted per instructions.
Guidance and Other Needed Information:	See the HPMS memo dated August 16, 2016 (*Pharmacy Directories and Disclaimers)* for information regarding electronic and hard copy directory requirements. Part D Model Materials
Translation Required (5%	Yes.

Plan Termination Notices (Communication)
(42 CFR §§ 422.508(a), 422.510(b), 422.512(b), 422.2267(e)(10), 423.508(b), 423.509(b), 423.510(b), 423.2267(e)(13))

To Whom Required:	Provided to affected enrollees before the plan termination effective date.
Timing:	CMS and Plan/Part D provider-initiated terminations require enrollee notices be sent as specified in CFR Title 42.
Method of Delivery:	• Notices must be hard copy and sent via U.S. mail. First class postage is recommended. • Notice to the general public requires publishing in one or more newspapers of general circulation.
HPMS:	Not applicable.
Format Specification:	Model required - Current contract year.
Guidance and Other Needed Information:	Relevant plan termination notice requirements are provided at §§ 422.111, 422.508, 422.510, 422.512, 422.2267, 423.508, 423.509, 423.510 and 423.2267.
Translation Required (5% Threshold):	Yes.

Pre-Enrollment Checklist (Communications)
(42 CFR §§ 422.2267(e)(4), 423.2267(e)(4))

To Whom Required:	Provided to potential enrollees with the Summary of Benefits (SB) when the SB is accompanying an enrollment form.
Timing:	Prior to enrollment.
Method of Delivery:	In the same format the SB was provided.
HPMS:	Not applicable.
Format Specification:	Standardized material. Modifications to disclaimer language not permitted, however, plans may delete bullets that do not apply to a specific plan type. If the pre-enrollment checklist is used for multiple products, additional language may be added before or after the disclaimer to clarify or distinguish how a disclaimer applies to products.
Guidance and Other Needed Information:	Must accompany the SB. Refer to Appendix 1.
Translation Required (5% Threshold):	Yes.

Prescription Transfer Letter (Communications)
(42 CFR § 423.2267(e)(16))

To Whom Required:	Provided to enrollees if a Part D sponsor is requesting permission to fill a prescription at a different network pharmacy than the one currently being used by enrollee.
Timing:	Ad hoc.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR § 423.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Needed Information:	Refer to the Part D Model Materials
Translation Required (5% Threshold):	Yes.

Provider Directory (Communications)
(42 CFR §§ 422.111(b)(3), 422.2267(e)(11))

To Whom Required:	Provided to all plan enrollees.
Timing:	• Provided to current plan enrollees by October 15 of the year prior to the applicable year. • Provided to new plan enrollees within 10 calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Plans must update directory information any time they become aware of changes. All updates to the online provider directories must be completed within 30 days of receiving information requiring update. Updates to hardcopy provider directories must be completed within 30 days, however, hardcopy directories that include separate updates via addenda are considered up-to-date
Method of Delivery:	Hard copy, or electronically, as permitted in 42 CFR § 422.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material. Current Contract Year Provider Directory. Modifications permitted per instructions.
Guidance and Other Needed Information:	Chapter 4 of the Medicare Managed Care Manual, and Medicare Advantage and Section 1876 Cost Plan Provider Directory Model.
Translation Required (5% Threshold):	Yes.

Provider Termination Letter to Beneficiaries (Communications)
(42 CFR §§ 422.111(e), 422.2267(e)(12))

To Whom Required:	Provided to all applicable enrollees, per 42 CFR §422.111(e), when their provider will no longer be part of the plan network.
Timing:	At least 30 days prior to the termination effective date.
Method of Delivery:	Notices must be hard copy and sent via U.S. mail (first class postage recommended). Plans may also send notices electronically if enrollee has opted into receiving electronic version as permitted in 42 CFR § 422.2267(d).
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Needed Information:	Chapter 4 of the Medicare Managed Care Manual.
Translation Required (5% Threshold):	Yes.

Safe Disposal Information (Communication)
(42 CFR §§ 422.111(j), 423.153(d)(1)(vii)(E) and (F))

To Whom Required:	Provided to enrollees in a plan's MTM program as part of the CMR, targeted medication review, or other MTM correspondence or service.
Timing:	At least once annually beginning on January 1, 2022.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in §§ 422,2267(d) and 423.2267(d).
HPMS:	Not applicable.
Format Specification:	No model required. This information must comply with all requirements of § 422.111(j).
Guidance and Other Needed Information:	See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM for Annual MTM Program Submission Instructions memo.
Translation Required (5% Threshold):	Yes.

Scope of Appointment (Communications)
(Sections 1851(j)(2)(A) and 1860D-04(l) of the Social Security Act;
42 CFR §§422.2264(c), 422.2266(d)-(f), 422.2274(b)-(c), 423.2264(c), 423.2266(d) and (e), 422.2274(b)-(c))

To Whom Required:	Documented for all marketing activities, in-person, telephonically, including walk-ins to plan or agent offices.
Timing:	Prior to the appointment.
Method of Delivery:	Signed hard copy, telephonic recording (telephonic appointments only), or electronically signed.
HPMS:	Not applicable.
Format Specification:	Model material.
Guidance and Other Needed Information:	The following requirements must be on the scope of appointment form or on the recorded call: • Product types to be discussed. • Date of appointment. • Beneficiary and agent contact information. • Statement stating, no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur. A new SOA is required if the beneficiary requests information regarding a different plan type than previously agreed upon.
Translation Required (5% Threshold):	Yes.

Star Ratings Document (Marketing)
(42 CFR §§ 422.2267(e)(13), (423.2267(e)(17))

To Whom Required:	Provided to all prospective enrollees when an enrollment form is provided. For online enrollment, Star Ratings document must be made available electronically (e.g., via link) prior to the completion and submission of enrollment request.
Timing:	Provided prior to enrollment.
Method of Delivery:	Hard copy or via electronic mechanism.
HPMS:	Must be uploaded within 21 calendar days of the release of the updated information.
Format Specification:	Standardized. Star Ratings document is generated from HPMS.
Guidance and Other Needed Information:	• New plans that have no Star Ratings are not required to provide until the following contract year. • Updated Star Ratings must be used within 21 calendar days of release of updated information on Medicare Plan Finder. • Updated Star Ratings must not be used until CMS releases Star Ratings on Medicare Plan Finder. • Only the plan logo may be added to the document (no other changes or alterations are permitted).
Translation Required (5% Threshold):	Yes.

Summary of Benefits (Marketing)
(42 CFR §§ 422.2267(e)(5), 423.2267(e)(5))

To Whom Required:	Provided to all prospective enrollees when an enrollment form is provided.
Timing:	Available by October 15 of each year.
Method of Delivery:	Hardcopy or electronic, depending on the format of the enrollment mechanism.
HPMS:	Submitted prior to October 15 of each year.
Format Specification:	Model material.
Guidance and Other Needed Information:	Refer to Appendix 2
Translation Required (5% Threshold):	Yes.

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Disclaimers

Disclaimer	42 CFR Section(s)	Model or Standardized Content	Applicable Documents and Notes
Federal Contracting Statement	422.2267(e)(30) 423.2267(e)(32)	**Model Content:** Disclaimer must include: • Legal or marketing name of the organization. • Type of plan (e.g., HMO, HMO SNP, PFFS, PDP). • A statement that the organization has a contract with Medicare (when applicable, plans may also state that the organization has a contract with the state/Medicaid program). • A statement that enrollment depends on contract renewal. Example: "[Plan's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [Plan's legal or marketing name] depends on contract renewal."	Required on all marketing materials except: Banners and banner-like advertisements, outdoor advertisements, text messages, social media, and envelopes. Plans should incorporate contract with state/Medicaid Program when appropriate.
Star Ratings	422.2267(e)(31) 423.2267(e)(33)	**Model Content:** • Convey that plans are evaluated yearly by Medicare • Convey that the ratings are based on a 5-star rating system Example: "Every year, Medicare evaluates plans based on a 5-star rating system."	Must be used whenever Star Ratings are mentioned in marketing materials, with the exception of when Star Ratings are published on small objects (e.g., that pens or rulers). Model content may be provided in disclaimer form or within the material. Because of the space limitations associated with electronic media such as search ads and social media, it is acceptable to provide the Star Ratings

Disclaimers

Disclaimer	42 CFR Section(s)	Model or Standardized Content	Applicable Documents and Notes
			disclaimer to the viewer when they click on the ad.
Accommodations	422.2267(e)(33) 423.2267(e)(34)	**Model Content:** • Convey that accommodations for persons with special needs is available. • Provide a telephone number and TTY number. Example: "For accommodations of persons with special needs at meetings call <insert phone and TTY number>."	Must be in any advertisement of invitations to all events as described under §§ 422.2264(c) and 423.2264(c). Model content may be provided in disclaimer form or within the material.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	422.2267(e)(32)	**Model Content:** • Convey the benefits mentioned are special supplemental benefits. • Convey that not all members will qualify. Example: "The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify."	Must be used whenever SSBCI benefits are mentioned. Model content may be provided in disclaimer form or within the material.

Disclaimers

Disclaimer	42 CFR Section(s)	Model or Standardized Content	Applicable Documents and Notes
Mailing Statements	422.2267(e)(34) 423.2267(e)(35)	**Standardized Content:** • Include the following statement when mailing information about the enrollee's current plan: "Important [Insert Plan Name] information." • Include the following statement when mailing health and wellness information: "Health and wellness or prevention information."	Must be included when mailing applicable information to current members. Must include the plan name. If the plan name is elsewhere on the envelope, it does not need to be repeated in the disclaimer. Delegated or sub-contracted entities and downstream entities that conduct mailings on behalf of a multiple plans must also comply with this requirement; however, they do not have to include a plan name.
Promotional Give-Away	422.2267(e)(35) 423.2267(e)(36)	**Model Content:** • Convey that there is no obligation to enroll in a plan. Examples: "Eligible for a free drawing, gift, or prizes with no obligation to enroll." "Free gift without obligation to enroll."	Required when offering promotional giveaways such as drawings, prizes, or free gifts. Model content may be provided in disclaimer form or within the material.

Disclaimers

Disclaimer	42 CFR Section(s)	Model or Standardized Content	Applicable Documents and Notes
Provider Co-branded Material	422.2267(e)(36) 423.2267(e)(37)	**Model Content:** • Convey, as applicable, that other pharmacies, physicians or providers are available in the plan's network. Example: "Other <Pharmacies/Physicians/Providers> are available in our network."	Must be used whenever co-branding relationships with network provider are mentioned, unless (for MA and cost plans (including MA-PD plans) only) the co-branding is with a provider network or health system that represents 90 percent or more of the network as a whole.
Out of Network Non-Contracted Provider	422.2267(e)(37)	**Standardized Content:** "Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services."	Must be included whenever materials reference out-of-network/non-contracted providers. Does not apply to standalone PDP plans.
NCQA SNP Approval Statement	422.2267(e)(38)	**Model Content:** • Convey that the MA organization has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP). • Include the last contract year of NCQA approval. • Convey that the approval is based on a review of [insert Plan Name's] Model of Care. • May not include numeric SNP approval scores. Example: "Based on a Model of Care review, [Insert Plan Name]	Required on all documents that reference NCQA SNP approval. Must be used by SNPs who have received NCQA approval.

Disclaimers

Disclaimer	42 CFR Section(s)	Model or Standardized Content	Applicable Documents and Notes
		has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through [insert last contract year of NCQA approval].”	

Agent/Broker Requirements (42 CFR §§ 422.2274, 423.2274)

§§ 422.2274(b), 423.2274(b) - Agent/broker requirements

State law determines activities that require a licensed agent/broker. Unless required by state law, the following do not require the use of state-licensed marketing representatives:

- Providing factual information;
- Fulfilling a request for materials; or,
- Taking demographic information in order to complete an enrollment application.

- To ensure beneficiaries are not mislead or confused, licensed agents/brokers who are customer service representatives cannot act simultaneously as both a customer service representative and a sales/marketing agent/broker. The agent/broker must clearly state to the beneficiary when their role changes to a marketing/sales role, subject to beneficiary request and concurrence.

§§ 422.2274(c), 423.2274(c) - MA organization oversight

- Plans must report, to their CMS Account Manager, all enrollments made by unlicensed agent(s) and for-cause terminations of agents/brokers.
- Plans must provide annual training and testing that meets CMS' requirements as found in the Agent and Broker Training and Testing Guidelines, posted yearly on the CMS.gov website.

§§ 422.2274(a), 423.2274(a) - Definitions

A "like plan type" enrollment includes:

- PDP replaced by another PDP
- An MA, MA-PD, or MMP to another MA, MA-PD, or MMP, or
- A Section 1876 Cost Plan to another Section 1876 Cost Plan.

§§ 422.2274(d)(3), 423.2274(d)(3) - Renewal compensation

- Renewal compensation may only be paid for enrollments into an MMP plan if permitted per state MMP policy.

§§ 422.2274(d)(5)(iii)(B), - Rapid Disenrollment Compensation

- Rapid disenrollment compensation recovery does not apply when dual eligible beneficiaries move from an MAPD to an MMP.

Appendix 1 – Standardized Pre-Enrollment Checklist (422.2267(e)(4), 423.2267(e)(4))

Instructions:
Plans must include the Standardized Pre-Enrollment Checklist with the enrollment form and the SB.

Plans may remove parts or portions of the checklist that are not applicable to a particular plan type or product. When the pre-enrollment checklist is used for multiple products, they may add additional language before or after the disclaimer to clarify or distinguish how a disclaimer applies to different products.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [insert customer service phone number].

Understanding the Benefits

☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [insert Plan website] or call [insert plan phone number] to view a copy of the EOC.

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐ In addition to your monthly plan premium [plans may delete the monthly plan premium portion for $0 premium plans], you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

> [**Note**: Fully integrated dual SNPs may elect to remove this section or modify it to convey that the Part B premium is already paid. Plans that have a Part B buy-down may alter the language to convey the amount the plan pays and the beneficiary owes.]

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, [insert year].

☐ [For plans that do not offer out of network coverage] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐ [For PPO, PFFS, and other plans that offer out of network coverage] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services [HMO-POS may insert "certain covered services"], the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. [If applicable, plans must add the following language] In addition, you will pay a higher co-pay for services received by non-contracted providers.

☐ [For C-SNP plans] This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

☐ [For D-SNP plans] This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. [D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies)]

☐ [For I-SNP plans] This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.

☐ [For MSAs] MSA Plans combine a high deductible Medicare Advantage Plan and a trust or custodial savings account (as defined and/or approved by the IRS). The plan deposits money from Medicare into the account. You can use this money to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount, so you generally have to pay money out of pocket before your coverage begins.

Medicare MSA Plans do not cover prescription drugs. If you join a Medicare MSA Plan, you can also join any separate Medicare Prescription Drug Plan.

There are additional restrictions to join an MSA plan, and enrollment is for a full calendar year unless you meet certain exceptions. Those who disenroll during the calendar year will owe a portion of the account deposit back to the plan. Contact the plan at [insert customer service and TTY] for additional information.

Appendix 2 – Model Summary of Benefits Instructions (422.2267(e)(5), 423.2267(e)(5))

Plans must reflect Part C and Part D benefits and cost sharing in the SB. If there is no cost sharing, plans must notate no costs (e.g., $0 cost for day six (6) and beyond). If the benefit is not offered, then notate that it is not offered. Part C benefits and cost sharing must be in the following order:

- Monthly plan premium (Part C and D premium combined);
- Part B premium buy-down, if applicable;
- Deductibles, including plan level and category level deductible;
- Maximum Out-of-Pocket Responsibility (does not include prescription drugs);
- Inpatient Hospital coverage;
- Outpatient Hospital coverage;
- Ambulatory Surgical Center (ASC) Services;
- Doctor Visits (Primary Care Providers and Specialists);
- Preventive Care;
- Emergency Care;
- Urgently Needed Services;
- Diagnostic Services/Labs/Imaging (include diagnostic tests and procedures, labs, diagnostic radiology, and X-rays);
- Hearing Services (Include mandatory and optional supplemental benefits);
- Dental Services (Include mandatory and optional supplemental benefits);
- Vision Services (Include mandatory and optional supplemental benefits); and,
- Mental Health Services.

In addition to the benefits in §§ 422.2267(e)(5)(ii), plans should include the following five (5) benefits in the SB under Part C:

- Skilled Nursing Facility;
- Physical Therapy;
- Ambulance;
- Transportation; and
- Medicare Part B Drugs.

Part D benefits must include:

- Cost sharing for deductible, the initial coverage phase, coverage gap, and catastrophic coverage. Cost sharing must be broken down by the tier number/name (e.g., tier 1 generic).

When applicable, a notation that costs may differ based on pharmacy type or status (e.g., preferred/non-preferred, mail order, long-term care (LTC), and 30- or 90-day supply).

To avoid beneficiary confusion when comparing plans, plans must maintain the above order of the data elements. The monthly premium, deductible and the maximum out-of-pocket cost must always be displayed first. Plans may then decide whether to display drug or health benefits next.

If any of the benefits are not offered (e.g., transportation), indicate them as "not covered." Plans may remove certain benefits if they are not applicable to a particular plan type (e.g., Part D only plan removes Part C benefits).

Additional benefits may be listed after all the required elements are provided in the SB. They may be listed after Part C or after Part C and D benefits.

Plans may list supplemental benefits for the chronically ill (SSBCI) in addition to Part C benefits and Part D.

When adding Value Added Items and Services (VAIS) in the SB:

- They should be placed in a separate section, distinguishable from the benefits;
- Services/items should not be called *benefits* as they are not part of the Medicare plan benefit package; and,
- Plans should provide language in the SB to make it clear that these additional services/items are not part of the plan benefit package or the Medicare benefit.

Please refer to Medicare Managed Care Manual, Chapter 4, Section 80 for additional information on VAIS.

Other required information in the SB:

- The document must be labeled as "Summary of Benefits" noting the plan year;
- The plan name and type must be clearly labeled for all Plans in the SB. For example, <Plan name, HMO or PPO, SNP, MSA, etc.>;
- Service area and eligibility requirements, including the Medicaid eligibility criteria applicable to Dual Eligible Special Needs Plans (D-SNPs);
- Phone number, including TTY/TDD;
- Days and hours of operation;
- Website address;
- In-network and out-of-network cost-sharing information for applicable plan types;
- Applicable disclaimers;
- Language stating that the complete list of services is found in the Evidence of Coverage (EOC), as well as language directing readers how to access or order the EOC;
- Language that directs readers how to access or order the "Medicare & You" handbook;
- If the SB includes plans with and without Part D prescription drug coverage, the distinction between plans must be clear;
- Notate services that require a physician referral or prior authorization; and
- If offering optional supplemental benefits, plans must include the additional premium amount.

D-SNPs

We encourage FIDE SNPs to work with their contracted State Medicaid agencies in developing an SB that displays integrated benefits.

Medicare Premium and Deductible:
Plans that use Medicare premium, deductible, or cost sharing amounts (e.g., inpatient hospital) must insert the current year's Medicare amounts. In addition, the category must also note that these amounts may change for the following year and the plan will provide updated rates at [insert website] as soon as Medicare releases them.

Overall design and layout:
Plans may present multiple plan benefit packages (PBPs) in the same document by displaying the benefits in separate columns. Plans using this option may include similar or different plan types (e.g., HMO to HMO, or HMO to PFFS, or HMO to PPO). Plans may also:

- Make use of colors to enhance the ability to navigate the document, or
- Incorporate various icons/graphics to help locate important information, such as how to complete an application online or contact customer service (e.g., phone number).

Note: SNPs must remain separate from non-SNP plans to avoid confusion for beneficiaries.

Recommendations:
The following recommendations are based on consumer testing:

- Avoid the use of multiple folds and large charts as it may make it cumbersome and difficult to use;
- Include definitions and purpose of the document;
- Avoid using dimensions that are too large as it could diminish the usefulness of the SB; and,
- Avoid the use of footnotes. If necessary to include footnoted information, visually emphasize (e.g., larger or bold font) the inclusion of superscripts in coverage charts.

HPMS Submission Process:
The SB is a File & Use document, and therefore must be submitted in HPMS under "CMS Required" as one document.

Appendix 3 – Employer/Union Group Health Plans

Sections 1857(i) and 1860D-22(b) of the Social Security Act; 42 CFR §§ 422.2276, 423.458, 423.2276

Plans offering employer group health plans including Employer Group Waiver Plans (EGWPs) are not required to submit communication and marketing materials specific only to those employer plans. However, as a condition of CMS providing particular waivers or modifications to employer group plans, CMS may request and review any materials in the event of beneficiary complaints or for any other reason it determines to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

CMS waivers to employer group plans are limited in scope to their stated parameters, and employer group plans (including EGWPs) must follow all rules in these guidelines unless CMS explicitly waives them. For specific guidance regarding these waivers, please refer to Chapter 9 of the Medicare Managed Care Manual and Chapter 12 of the Medicare Prescription Drug Benefit Manual.

Marketing Provisions Table – Employer/Union Group Plans

These requirements are applicable to the transaction between the agent/broker selling the plan to the employer/union. All activities conducted by the employer/union or its designees to sign up individual employees to the plan(s) selected by the employer/union are excluded from these provisions.

Note: This table contains a partial list of exclusions.

Applicable Provisions (Not Waived)	Not Applicable Provisions (Waived)
Nominal Gifts	Unsolicited Contacts
Sales/Marketing in Health Care Settings	Cross-selling
Sales/Marketing at Educational Events	Scope of Appointments
Co-branding	Provision of Meals
Appointment of Agents/Brokers	Agent/Broker Compensation
State Licensure Requirements	Agent/Broker Testing
Reporting of Terminated Agents/Brokers	CMS Prior Review of Marketing Materials
Agent/Broker Training Agents must be thoroughly familiar with the products they are selling, including the plan specific details and the Medicare rules that apply to the specific products. The organization/sponsor is responsible for ensuring that the agents selling for them have sufficient knowledge.	Pre-Enrollment Checklist

Appendix 4 – Use of Medicare Mark for Part D Sponsors

Section 1140 of the Social Security Act

All plans may use the Medicare Prescription Drug Benefit Program Mark only after electronically executing the Medicare Mark License Agreement in HPMS. Only a CEO, CFO, or COO who is designated as an authorized signer in HPMS is eligible to execute the Medicare Mark License Agreement. In certain circumstances, the Medicare Mark License Agreement may be signed in hard copy. The license agreement is effective for a single contract year and plans must renew annually to continue using the mark. Unless otherwise approved, no individuals, organizations, and/or commercial firms may distribute materials bearing the Medicare Prescription Drug Benefit Program Mark. Plans may use the mark on communications and marketing materials consistent with this chapter.

Use of Medicare Prescription Drug Benefit Program Mark on Items for Sale or Distribution

Section 1140 of the Social Security Act

All plans may use the Medicare Prescription Drug Benefit Program Mark on items they distribute, provided the item(s) follow(s) guidelines for nominal gifts, as provided in 42 CFR § 423.2263(b)(2). Plans cannot sell items with the Medicare Prescription Drug Benefit Program Mark for profit.

Approval to Use the Medicare Prescription Drug Benefit Program Mark

Plans must submit requests to distribute other items (materials that are not included in this chapter) bearing the Medicare Prescription Drug Benefit Program Mark to CMS at least 30 days prior to the anticipated date of distribution. Plans should send requests sent to:

Office of the Administrator
Office of Communications
Visual & Multimedia Communications Group
7500 Security Blvd.
Baltimore, MD 21244-1850

Once CMS has approved a request, the following will apply: 1) approval will be effective for a period not to exceed one year; and 2) approval will be granted only for those items for which use of the mark was requested in the request letter and for which CMS granted written approval.

Prohibition on Misuse of the Medicare Prescription Drug Benefit Program Mark Section 1140 of the Social Security Act

42 U.S.C. section 1320b-10 prohibits the misuse of the Medicare name and marks. In general, it authorizes the Inspector General of DHHS to impose penalties on any person who misuses the term Medicare or other names associated with DHHS in a manner which the person knows or should know gives the false impression that DHHS has approved, endorsed, or authorized it. Offenders are subject to fines of up to $5,000 per violation or in the case of a broadcast or telecast violation, $25,000.

Mark Guidelines
Section 1140 of the Social Security Act

The Medicare Prescription Drug Benefit Program Mark is a logotype comprised of the words Medicare Rx with the words Prescription Drug Coverage directly beneath.

Always use reproducible art available electronically. Do not attempt to recreate the Program Mark or combine it with other elements to make a new graphic. Artwork will be supplied in .EPS, .TIFF or .JPG format after notification of approval into the program.

Mark Guidelines - Negative Program Mark
Section 1140 of the Social Security Act

The Medicare Prescription Drug Benefit Program Mark may be reversed out in white. The entire mark must be legible.

Mark Guidelines - Approved Colors
Section 1140 of the Social Security Act

The two (2)-color mark is the preferred version. It uses PMS 704 (burgundy) and sixty-five (65) percent process black. It is recommended that if the CMS mark is used in conjunction with the brand mark, that the black versions of those logos be used.

The 1-color version in one-hundred (100) percent black also is acceptable.

Mark Guidelines on Languages
Section 1140 of the Social Security Act

The Spanish version of the Medicare Prescription Drug Benefit Program Mark may be used in place of the English language version on materials produced entirely in Spanish. The two (2)-color version is preferred, but the grayscale, black and negative versions may be used.

Mark Guidelines on Size
Section 1140 of the Social Security Act

To maintain clear legibility of the Program Mark, never reproduce it at a size less than one (1) inch wide. The entire mark must be legible.

Mark Guidelines on Clear Space Allocation
Section 1140 of the Social Security Act

The clear space around the Medicare Prescription Drug Benefit Program Mark prevents any nearby text, image or illustration from interfering with the legibility and impact of the mark. The measurement “x” can be defined as the height of the letter “x” in “Rx” in the Program Mark. Any type or graphic elements must be at least “x” distance from the mark as shown by the illustration.

Mark Guidelines on Bleed Edge Indicator
Section 1140 of the Social Security Act

The Program Mark may not bleed off any edge of the item. The mark should sit at least one--eighth (1/8) inch inside any edges of the item.

Mark Guidelines on Incorrect Use
Section 1140 of the Social Security Act

Following are rules for preventing incorrect use of the Medicare Prescription Drug Benefit Program Mark:

- Do not alter the position of the mark elements;
- Do not alter the aspect ratio of the certification mark;
- Do not stretch or distort the mark;
- Always use the mark only as provided in the CMS approval/license agreement;
- Do not rotate the mark or any of its elements;
- Do not alter or change the typeface of the mark;
- Do not alter the color of any of the mark elements;
- Do not position the mark near other items or images. Maintain the clear space allocation;
- Do not position the mark to bleed off any edge. Maintain one-eighth (1/8) inch safety from any edge;
- Do not use any of the mark elements to create a new mark or graphic; and
- Do not use the mark on background colors, images or other artwork that interfere with the legibility of the mark.

Mark Guidelines for Part D Standard Pharmacy ID Card Design
Section 1140 of the Social Security Act

Use of the Medicare Prescription Drug Benefit Program Mark on an ID card must be consistent with guidance mentioned in this section.


Part D Plan Sponsor Name/Logo
sponsor logo place-holder
RxBin 999999
RxPCN ABC1234567
RxGrp ABC123456789
Issuer (80840)
ID 12345678901
Name JOHN Q PUBLIC
MedicareRx
Prescription Drug Coverage
CMS - S5555 XXXX

Appendix 5 – External Links

CMS Eligibility and Enrollment Guidance
https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol

CMS Medicare Online Enrollment Center:
https://www.medicare.gov/plan-compare/

CMS Plan Finder
https://www.medicare.gov or 1-877-486-2048)
https://www.medicare.gov/plan-compare/

CMS Star Ratings
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData

HIPAA Privacy Rule and Disclosure Requirements
https://www.hhs.gov/hipaa/index.html

HIPAA Privacy Rule and Security Requirements
https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/significant-aspects/index.html

Internal Revenue Service (IRS) Tax publications
https://www.irs.gov or 1-800-TAX-FORM (1-800-829-3676)

Medicare.gov Complaint Website
https://www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare Managed Care Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

Medicare Part D Model Materials
https:www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials

Medicare Prescription Drug Benefit Manual
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals

Medicare Coverage Database
https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx

Medicare Coverage Determinations (MCD)
https://www.cms.gov/medicare-coverage-database/reports/reports.aspx

Section 508 of the Rehabilitation Act
https://www.hhs.gov/web/section-508/index.html

State-specific marketing guidance for MMPs

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources

WEDI Health Identification Card Implementation Guide
https://www.wedi.org

Medicare Managed Care Manual

Chapter 2 - Medicare Advantage Enrollment and Disenrollment

Updated: August 19, 2011
(Revised: November 16, 2011, August 7, 2012, August 30, 2013, August 14, 2014, July 6, 2015, September 1, 2015, September 14, 2015, December 30, 2015, May 27, 2016, August 25, 2016, June 15, 2017, July 31, 2018 *& August 12, 2020*)

This guidance update is effective for contract year *2021*. All enrollments with an effective date on or after January 1, *2021*, must be processed in accordance with the revised requirements, including *the* new model *Medicare Advantage (MA)*enrollment form *for the 2021 plan year starting October 15, 2020* and *model* notices, as appropriate. Organizations may, at their option, implement any new requirement consistent with this guidance prior to the required implementation date.

It is expected that organizations will assure compliance with all Medicare Advantage requirements described in this chapter regarding communications made with beneficiaries/members, including the use of the model notices, and the requirements outlined in the Medicare Communications and Marketing Guidelines (MCMG).

Organizations are required to provide information to individuals in accessible/alternate formats (for example, Large Print, Braille), upon request and thereafter, as outlined in Section 504 of the Rehabilitation Act of 1973 (and subsequent revisions). Such individuals must have an equal opportunity to participate in enrollment, paying premium bills, and communicating with the plan, as members who do not request accessible/alternate formats.

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For Chapter 2, a reference to an "MA plan" includes MA local plans, MA Regional Preferred Provider Organization (PPO) plans and MA-PD plans (including special needs plans), unless otherwise specified.

The instructions provided in this chapter apply to MA plans, including MA-PD plans. Instructions for enrollment (and disenrollment) in a Prescription Drug Plan (PDP) or an 1876 cost plan are provided in a separate guidance.

10 - Definitions

The following definitions relate to topics addressed in this guidance.

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 below. Plans must use this date in the appropriate field when submitting enrollment transactions to CMS. A summary of application dates for CMS enrollment transactions is provided in Appendix 3 of this guidance.

- For requests sent by mail, the application date is the date the application is received by the organization (i.e., arrives in the organization's mailbox or mailroom); the postmark is irrelevant).
- For requests received by fax, the application date is the date the fax is received on the organization's fax machine.
- For requests submitted to sales agents, including brokers, the application date is the date the agent and/or broker receives (accepts) the enrollment request and not the date the organization receives the enrollment request from the agent and/or 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.
- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and have been recorded.
- The Medicare.gov Online Enrollment Center (OEC) uses coordinated Universal Time (UTC, which was formerly known as Greenwich Meant Time and is four hours ahead of Eastern Daylight Time and five hours ahead of Eastern Standard Time) as the system time to generate the timestamp of when an enrollment was received. For requests made via the (OEC), the application date to be used for processing the enrollment request is the time and date that is 11 hours earlier than the time and date CMS "stamps" on the enrollment request at the time the individual completed the OEC process. This is true regardless of when an organization ultimately retrieves or downloads the request.

  Example: An individual completes an enrollment request and submits it via the OEC at 9:00 p.m. EST on December 7. The OEC will "stamp" this request as having been completed on December 8 at 2:00 a.m., which is the UTC equivalent time and date. The organization will use December 7, 3:00 p.m., as the application date for the purpose of addressing CMS enrollment policy requirements (e.g. application date, determination of election period, etc.).

- For electronic enrollment requests made using the organization's system instead of the OEC, the application date is the date the applicant completes the request through the organization's electronic enrollment process. This is true regardless of when an organization ultimately retrieves or downloads the request.
- For all enrollments into employer group or union sponsored plans using the Special Enrollment Period for Employer or Union Group Health Plans (SEP EGHP), the application date used on the transaction submitted to CMS will always be the first of the month prior to the effective date of enrollment for all mechanisms at all times. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the organization receives the request. For example, if a valid group enrollment mechanism file is received by the organization on January 24th for enrollments effective February 1st, the receipt date for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.
- For auto- or facilitated enrollment, as described in §40.1.5, the application date is the first day of the month prior to the effective date of the auto/facilitated enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.

At-risk Beneficiary – A Part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at *42 CFR* 423.153(f). Additional guidance about Part D drug management programs is available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Authorized Representative/Legal Representative – An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, 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 (see §40.2.1). 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.

Cancellation of Enrollment Request – An action initiated by the beneficiary to cancel an enrollment request. To be valid, the cancellation request must be received by the organization before the enrollment effective date. An enrollment request that has been appropriately cancelled is considered not to have been used and the election remains available for use within the time frame of the applicable election period.

Completed Election – An enrollment request is considered complete when:

1. The form/request is signed by the beneficiary or legal representative (refer to §40.2.1 for a discussion of who is considered to be a legal representative), or the enrollment request mechanism is completed;

2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare Advantage organization (see below for definition of "evidence of Medicare Part A and Part B coverage");

3. All necessary elements on the form are completed (for enrollments, see Appendix 2 for a list of elements that must be completed) or when the enrollment request mechanism is completed as CMS directs, and, when applicable;

4. Certification of a legal representative's authority to make the enrollment request is obtained by attestation (refer to §40.2.1).

5. For Special Needs Plans (SNP), verification of SNP eligibility, as described in §20.11. Chronic condition SNPs (C-SNP) that utilize a CMS-approved pre-enrollment qualification assessment tool will consider the enrollment request to be complete upon receipt of the completed tool.

If an individual is involuntarily disenrolled for failure to pay premiums, to re-enroll in that plan, or enroll into another, he or she would need to request enrollment during a valid enrollment period. In addition, for enrollments into an MA-only (non MA-PD) plan, an MA organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the MA organization for a prior enrollment before considering an enrollment "complete."

Continuation Area/Continuation of Enrollment Option – A continuation area is an additional CMS-approved area outside the MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA local plan's continuation of enrollment members. MA organizations have the option of establishing continuation areas for MA local plans.

Conversions – For individuals who are enrolled in a health plan offered by the MA organization the month immediately before the month of their entitlement to Medicare Parts A and B, their enrollment in an MA plan offered by the same organization is referred to as a "conversion" from non-Medicare status to MA enrollee status. In order for the individual's enrollment with the organization as an MA enrollee to take effect upon becoming eligible for Medicare, conversions must take place during the individual's Initial Coverage Election Period (ICEP).

Denial of Enrollment Request – Occurs when an MA organization determines that an individual is not eligible to make an enrollment request (e.g., the individual is not entitled to Medicare Part A or enrolled in Part B, the individual is not making the enrollment request during an election period, etc.), and therefore determines it should not submit the enrollment request transaction to CMS.

Effective Date of Coverage/Enrollment – The date on which an individual's coverage in an MA plan begins. The MA organization must determine the effective date of enrollment for all enrollment requests. Instructions for determining the correct effective date of coverage are provided in §30.6.

Election – Enrollment in, or voluntary disenrollment from, an MA plan or the traditional Medicare fee-for-service program ("Original Medicare") constitutes an election. (Disenrollment from Original Medicare would occur only when an individual enrolls in an MA plan.) The term "election" is used to describe either an enrollment or voluntary disenrollment. If the term "enrollment" is used alone, however, then the term is used deliberately, i.e., it is being used to describe only an enrollment, and

not a disenrollment. The same applies when the term "disenrollment" is used alone, i.e., the term is being used to describe only a disenrollment, and not an enrollment.

Election Period – The time(s) during which an eligible individual may request to enroll in or disenroll from an MA plan. The type of election period determines the effective date of MA coverage as well as the types of enrollment requests allowed. There are several types of election periods, all of which are defined under §30.

Enrollment Request Mechanism – A method used by individuals to request to enroll in an MA plan. Several model individual enrollment forms are provided in the Exhibits at the end of this guidance. **An individual who is a member of an MA plan and who wishes to elect another MA plan, even if it is offered by the same MA organization, must complete a new election during a valid enrollment period to enroll in the new MA plan**. However, that individual may use a short enrollment form (refer to Exhibit 3) or a "plan selection" form (refer to Exhibit 3a) to make the election in place of the comprehensive individual enrollment form, or, may complete the election via an electronic enrollment mechanism, as described in §40.1.2 of this guidance, or by telephone, as described in §40.1.3 of this guidance, if the MA organization offers these options. In addition, MA organizations may want to collaborate with Employer or Union Group Health Plans (EGHPs) to use a single enrollment form (or other CMS approved method, if available) for EGHP members; a model EGHP enrollment form for this purpose is provided in Exhibit 2. Beneficiaries or their legal representatives must complete an enrollment request mechanism (e.g. enrollment form) to enroll in an MA plan.

Beneficiaries are not required to use a specific form to disenroll from an MA plan; however, a model disenrollment form is provided in Exhibit 10.

Evidence of Entitlement (Medicare Part A and Part B Coverage) – Documentation, materials or other information that confirms an individual is entitled to coverage under Parts A and B of Medicare. Evidence of entitlement is a requirement to determine eligibility for enrollment into a MA plan. It includes the individual's coverage start dates for Part A and Part B. CMS systems are updated within two business days of SSA processing a new or changed Part A or Part B entitlement. MA organizations must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). Therefore, the applicant is not required to provide evidence with the enrollment request.
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Evidence of Permanent Residence – A permanent residence is normally the enrollee's primary residence. An MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills to verify the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

Full-Benefit Dual Eligible Individual – For purposes of Medicare Prescription Drug benefits (Part D), is a Medicare beneficiary who is determined eligible by the state for medical assistance for full benefits under title XIX of the Social Security Act for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act, or medical assistance under section 1902(a)(10)(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

Good Cause – This term refers to the standards established in § 60.3.4 under which an individual may be reinstated into his/her MA plan when involuntarily disenrolled for failure to pay the plan's premium or the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) premium amount.

Incarceration – This term refers to the status of an individual who is in the custody of a penal authority and confined to a correctional facility, such as a jail or prison, or a mental health institution as a result of a criminal offense. Such individuals reside outside of the service area for the purposes of MA plan eligibility, even if the correctional facility is located within the plan service area. Individuals who are confined to Institutions for Mental Disease (IMDs), such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, as a result of violations of the penal code, are incarcerated as CMS defines the term for the purpose of MA eligibility. The place of residence for these confined individuals is therefore excluded from the service area of an MA plan on that basis.

Individuals who are confined to IMDs, such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, for other reasons (e.g., because of court orders unrelated to penal violations) are not incarcerated. Normal service area rules apply to these individuals.

Institutionalized Individual – *Please refer to 42 CFR 422.2*.

Involuntary Disenrollment – Disenrollments made necessary due to the organization's determination that the individual is no longer eligible to remain enrolled in a plan, or when an organization otherwise initiates disenrollment (e.g. failure to pay plan premiums, plan termination). Procedures regarding involuntary disenrollment are found in §§50.2 and 50.3.

Late Enrollment Penalty (LEP) – An amount added to the MA-PD plan premium of an individual who did not obtain creditable prescription drug coverage when s/he was first eligible for Part D or who had a break in creditable prescription drug coverage of at least 63 consecutive days. The LEP is considered a part of the plan premium.

Lawfully Present Individual – Refer to 8 CFR 1.3 (Lawfully present aliens for purposes of applying for Social Security benefits) for a definition of an alien who is considered lawfully present in the United States. An individual who is not lawfully present in the Unites States is not eligible for any federal public benefit, including payment of Medicare benefits. (8 U.S.C. 1611)

Medicare Advantage Organization (MA organization) - Refer to Chapter 1 (General Provisions) for a definition of an "MA organization."

MA Organization Error – An error or delay in enrollment request processing made under the full control of the MA organization personnel and one that the organization could have avoided.

Medicare Advantage Plan – Refer to Chapter 1 for a definition of "MA plan." Enrollment requests are made at the MA **plan level**, not at the **MA organization level.**

Other Low Income Subsidy (LIS) Eligible Individuals – For purposes of Medicare Part D benefits, individuals who are determined eligible for the Part D low-income subsidy (LIS) who are not full-benefit dual eligible individuals as defined above. This includes individuals deemed eligible for LIS by virtue of having QMB-only, SLMB-only, QI, SSI-only; as well as those who apply and are determined eligible for LIS.

Out-of-Area Members - Members of an MA plan who live outside the service area and who elected the MA plan while residing outside the service area (as allowed in §§20.0, 20.3, 50.2.1, and 50.2.4).

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) – A premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. The Social Security Administration assesses the amount annually based on the enrollee's available tax information. The plan does not collect the Part D-IRMAA as part of its premium. Typically, individuals pay the Part D-IRMAA through their Social Security, Office of Personnel Management or Railroad Retirement Board (RRB) benefit withholding. Some enrollees are directly billed for their Part D-IRMAA through invoices sent by CMS or the RRB. All Part D enrollees who are assessed the Part D-IRMAA are required to pay the IRMAA even if the Part D coverage is provided through an EGHP.

Plan Performance Rating – A CMS-assigned rating, measured in stars from one to five, which indicates an organization's quality and performance based on criteria established by CMS. A star rating of one star indicates poor performance, while a star rating of five stars indicates exemplary performance. The Plan Performance Overall Rating (or "overall rating") is publicly available on Medicare.gov. CMS assigns the rating in October for the following year based on the organization's most recent quality and performance data.

Potential At-risk Beneficiary – A Part D eligible individual who is identified as being potentially at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at *42 CFR* 423.153(f). Additional guidance about Part D drug management programs is available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.htm
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Receipt of Enrollment Request – MA organizations may receive enrollment requests through various means, as described in §40.1. The MA organization must date as received all enrollment requests as soon as they are initially received. This date will be used to determine the election period in which the request was made, which in turn will determine the effective date of the request. Please refer to the definition of "Application Date" in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.

Reinstatement of Election – An action that may be taken by CMS to correct an erroneous disenrollment from an MA plan. The reinstatement corrects an individual's records by canceling a disenrollment to reflect no gap in enrollment in an MA plan. A reinstatement may result in retroactive disenrollment from another Medicare managed care plan.

Rejection of Enrollment Request – Occurs when CMS has rejected an enrollment request submitted by the MA organization. The rejection could be due to the MA organization incorrectly submitting the transactions, to system error, or to an individual's ineligibility to elect the MA plan.

Special Needs Plan – Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including; institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.

System Error – A "system error" is an unintended error or delay in enrollment request processing that is clearly attributable to a specific Federal government system (e.g., Social Security Administration (SSA) system, Railroad Retirement Board (RRB) system), and is related to Medicare entitlement information or other information required to process an enrollment request.

Voluntary Disenrollment – Disenrollment initiated by a member or his/her authorized representative.

20 - Eligibility for Enrollment in MA Plans

42 CFR 422.50

(Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

In general, an individual is eligible to elect an MA plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he or she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under §20.6);

2. *Effective for plan years beginning on or after January 1, 2021, a beneficiary with ESRD can choose to join a MA plan. (For additional information on SNP eligibility criteria, see Chapter 16-B Special Needs Plans).*

3. The individual permanently resides in the service area of the MA plan (see exceptions in §20.3 for persons living outside the service area at the time of the enrollment request);

4. The individual is a U.S. citizen or lawfully present in the United States (see exceptions in §20.3.2 for persons unlawfully present at the time of the enrollment request);

5. The individual or his/her legal representative completes an enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 2 for a list of items required to complete the enrollment form, and §40.2.1 for who may sign enrollment request forms or complete other enrollment request mechanisms);

6. The individual is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment request; and

7. The individual makes a valid enrollment request that is received by the plan during an election period, as described in §30;

8. For a Special Needs Plan (SNP) additional requirements apply as described in §20.11 of this guidance.

9. For an MSA plan, additional requirements apply as described in §20.10 of this guidance.

An MA organization may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in this guidance.

An MA organization must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in an MA plan and continues to be enrolled in his/her employer/union or spouse's group health benefits plan, then coordination of benefits rules apply.

An MA eligible individual may not be enrolled in more than one MA plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described in §§ 60.1, 60.2 and 60.3.

Individuals enrolled in an MA plan may not concurrently enroll in a PDP except for individuals enrolled in a Medicare MSA plan or individuals enrolled in a PFFS plan that does not offer Medicare prescription drug coverage. An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract the organization offers another PFFS plan that includes a Part D benefit.

20.1 - Entitlement to Medicare Parts A and B and Eligibility for Part D

To be eligible to elect an MA plan, an individual must be entitled to Medicare Part A and enrolled in Part B, and must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for Part B-only "grandfathered" members are outlined in §20.6. Part B only individuals currently enrolled in a plan created under §1833 or §1876 of the Social Security Act (the Act) are not considered to be "grandfathered" individuals, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.

An MA organization has the option to continue to offer Part A-equivalent coverage to Medicare Part B-only "grandfathered" members, as described in §20.6. However, an MA organization may not offer Part A-equivalent coverage to other individuals enrolled only in Medicare Part B (and not entitled to Part A) in order to make them "eligible" for enrollment in an MA plan. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the MA organization. The MA organization may refer the individual to SSA if the individual wishes to enroll in Medicare Part A in order to be eligible to enroll in the MA plan.

Eligibility for Part D does not exist:

- When the beneficiary is incarcerated.
- When the beneficiary is not lawfully present in the United States.
- When the beneficiary lives abroad.
- For any month prior to the month of notification of the entitlement determination when the entitlement determination for Part A and B is made retroactively.

MA-PDs may not enroll an individual who is not eligible for Part D.

20.2 - Place of Permanent Residence

42 CFR 422.2 and 422.50(a)(3)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

An individual is eligible to elect an MA plan if he or she permanently resides in the service area of the MA plan. A temporary move into the MA plan's service area does not enable the individual to elect the MA plan; the MA organization must deny such an enrollment request.

Incarcerated individuals reside outside of the plan service area for the purposes of MA eligibility, even if the correctional facility, institution or other place of confinement is located within the plan service area (see §10 for definition of "incarceration").

EXCEPTIONS

- An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area (refer to §20.8 for more detail on the requirements for the continuation of enrollment option).

- Conversions: Individuals who are enrolled in a health plan of the MA organization and are converting to Medicare Parts A and B can elect an MA local plan offered by the same MA organization during their ICEP even if they reside in the MA organization's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.)

- A member who was enrolled in an MA plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may remain enrolled in the MA plan while living outside the plan's new reduced service area if:

    - There is no other MA plan serving the area at that time;
    - The MA organization offers this option; and
    - The member agrees to receive services through providers in the MA plan's service area.

- The MA organization has the option to also allow individuals who are converting to Medicare Parts A and B to elect the MA plan during their ICEP even if they reside outside the service and continuation area. This option may be offered provided that CMS determines that all applicable MA access requirements in 42 CFR 422.112 are met for that individual through the MA plan's established provider network providing services in the MA plan service area, and the organization furnishes the same benefits to the individual as to members who reside in the service area. The organization must apply the policy consistently for all individuals. These members will be known as "out-of-area" members. This option applies both to individual members and to employer or union sponsored group plan members of the MA organization.

Individuals who do not meet the above requirements may not elect the MA plan. The MA organization must deny enrollment to these individuals.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but an MA organization may request additional information such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the MA organization must contact the individual to confirm that the individual resides in the service area. If there is a dispute over where the individual permanently resides, the MA organization should determine whether, according to the law of the MA organization's State, the person would be considered a resident of that State.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

MA organizations have the option to offer "visitor" or "traveler" programs for currently enrolled individuals who are consecutively out of the area for up to 12 months, provided the plan includes the full range of services available to other members (refer to §50.2.1 for more detail on the requirements for the "visitor/traveler" option). Residence in an area designated for a "visitor" or "traveler" program does not make an individual eligible to enroll in an MA plan, but rather applies to already enrolled individuals.

20.2.1 - Mailing Address

As described in §20.3, an individual's eligibility to enroll in an MA plan is in part determined by the individual's permanent residence in the service area of that MA plan. Some individuals may have separate mailing addresses that may or may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, such as that of a relative, MA organizations should make every effort to accommodate these requests, and should use this alternate address to provide required notices and other plan mailings, as appropriate. The model MA plan enrollment application forms provided in this guidance include a mechanism to collect a mailing address. Use of an alternate address does not eliminate or change the requirement of residency for the purposes of MA plan eligibility.

20.2.2 – U.S. Citizenship or Lawful Presence

An individual is eligible to elect enrollment in a MA plan if he or she is a U.S. citizen or lawfully present in the United States. CMS will notify the MA organization if the individual is not eligible to enroll on this basis at the time of enrollment. The MA organization must deny an enrollment request from an individual who does not meet this requirement.

> EXCEPTION: In the case where CMS systems show that an individual will have lawful presence status on or before the enrollment effective date, the plan must accept and process the enrollment request. An MA organization must not deny an enrollment request on the basis that the applicant is not lawfully present at the time the request is received if CMS systems indicate that he or she will be lawfully present in the United States as of the enrollment effective date.

If an individual provides evidence of their lawful presence status to the MA organization, the organization may not consider it when determining eligibility for enrollment. The organization may not request from an applicant any documentation of U.S. citizenship or alien status. CMS will provide the official status to the MA organization at the time of enrollment. However, if an individual has evidence of their lawful presence status and there is a dispute over their status, the MA organization should refer the individual to the Social Security Administration to have their status reviewed and adjusted, if necessary.

20.3 - Completion of Enrollment Request

42 CFR 422.50(a)(5)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

The Medicare beneficiary (or their legal representative, as described in § 40.2.1) must complete an enrollment request in order to enroll in an MA plan, even if switching plans in the same MA organization. To consider an election complete, the individual must:

- Complete an enrollment request;

- Provide required information to the MA organization within the required time frames; and
- Submit the completed request to the MA organization during a valid enrollment period.

This is required for all enrollments, unless otherwise specified by CMS.

Individuals may use any of the enrollment mechanisms offered by the MA organization to make their enrollment request. See § 40.1 for more information on the types of enrollment mechanisms allowed.

Individuals switching plans in the same MA organization may use a shortened enrollment form (sample Exhibit 3 or 3a). Individuals new to Medicare who are already a member of the organization's non-Medicare coverage (commercial, Medicaid, Marketplace) may use the simplified enrollment mechanism, if the MA organization chooses to offer it.

An MA organization must deny enrollment to any individual who does not properly complete the enrollment form or other mechanism within required time frames. Procedures for completing the enrollment request are provided in §40.2 and Appendix 2. Refer to §10 for a definition of "completed enrollment request."

20.3.1 - Optional Employer/Union Enrollment Request Mechanism

Beginning April 1, 2003, MA organizations that offer MA plans to an employer or union may choose to accept voluntary enrollment requests directly from the employer or union (or its Third Party Administrator (TPA)) without obtaining a paper MA enrollment request form from each individual. The enrollment requests reported to the MA organization by the employer/union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan. This enrollment request mechanism is optional for MA organizations, and may not be required. Therefore, MA organizations may specify the employers and/or unions, if any, from which they will accept this enrollment request format and may choose to accept enrollment and/or voluntary disenrollment requests.

The record of an individual's choice of health plan submitted by the employer or union effectively replaces the paper MA enrollment request form(s). All eligibility, processing and notice requirements, as outlined in this guidance and other references, that pertain to paper enrollment request forms are applicable to this enrollment request mechanism; however, this process does not require the MA organization to obtain a signature. Detailed information and instruction is provided in §40.1.2 for enrollments and §50.1.5 for disenrollments.

Notices of disenrollment, cancellation or termination of coverage not initiated by an enrollee enrollment request (i.e. involuntary disenrollment) are not included in this mechanism. Guidance for these situations is available in §50.1.5.

Additional information regarding employer/union sponsored group health plans can be found in Chapter 9 of this manual.

20.3.2 - Passive Enrollment by CMS

42 CFR 422.60(g)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Passive enrollment is a process where CMS enrolls an individual into another plan under certain circumstances specified below (note that CMS may also enroll individuals in plans under auto- and facilitated enrollment per § 40.1.5 and reassignment per § 40.1.8). The beneficiary receives a notice of this change and has the opportunity to accept or decline it. If the individual takes no action, the individual has made a choice to accept the enrollment. Passive enrollments are permitted in specific, limited circumstances associated with:

- Immediate plan terminations,
- Situations in which remaining enrolled in the plan would pose potential harm to members, and
- Situations where CMS determines passive enrollment is necessary to promote integrated care and continuity of care for full-benefit dual eligible beneficiaries.

CMS will determine when passive enrollment is appropriate under *42 CFR* 422.60(g) and will initiate contact through the MA organization's CMS account manager. CMS will consult with the state Medicaid agency and may authorize passive enrollment for full-benefit dual eligible beneficiaries enrolled in an integrated dual-eligible special needs plan (D-SNP) to continue access in integrated care, including when:

- The organization's Medicaid managed care plans non-renew because the state awards these contracts to another organization, or
- An integrated D-SNP non-renews at the end of the contract year.

CMS will provide specific instructions directly to the affected organizations (both the plan losing the member and the plan receiving the member) regarding processing the enrollments and specific information relevant to the situation for inclusion in notices.

Notices:

Organizations receiving passive enrollments must send required notices. The chart below outlines the requirements and timing:

Passive enrollment due to immediate plan termination or potential harm to members	**Passive enrollment to continue access to integrated care**
1 notice required	2 notices required
Notice language must: • describe the costs and benefits of the plan; • outline the process for accessing care in the plan; and • explain the ability to decline the enrollment or choose another plan, how to take that action and by when	Each notice language must: • describe the costs and benefits of the plan; • outline the process for accessing care in the plan; and • explain the ability to decline the enrollment or choose another plan, how to take that action and by when
Notice language must be approved by CMS	Notice language must be approved by CMS
Notice must be sent: • prior to the date coverage in the plan begins; or • as soon as possible after coverage in the plan begins, if prior notice isn't practical	Notice must be sent: • at least 60 calendar days prior to the date coverage in the plan begins; and • at least 30 calendar days prior to the date coverage in the plan begins

Evaluation of Plans Receiving Passive Enrollments:
For passive enrollment, CMS evaluates the receiving plan as noted in the following chart.

Passive enrollment due to immediate plan termination or potential harm to members	**Passive enrollment to continue access to integrated care**
Key criteria CMS may use:	Requirements (all must be met):
Similar or lower out-of-pocket maximum	Currently operate as a fully integrated dual eligible SNP (FIDE SNP) or qualify to meet Medicare-Medicaid integration criteria as D-SNP that meets a higher standard of integration (see Chapter 16b)
Similar or lower hospital cost-sharing amount	Substantially similar provider and facility networks
No additional network restrictions	Substantially similar Medicare and Medicaid covered benefits
Premium isn't significantly higher	Have limits on premiums and cost-sharing that are appropriate for full-benefit dually eligible beneficiaries (CMS interprets this standard as having no premium or cost-sharing ($0) (see Chapter 16b)
Equivalent or higher value Part D benefit and formulary structure	Have overall MA star rating of at least 3 stars (Exception: plan is low enrollment contract or new plan without star ratings)
Similar Part B buy-down feature, if applicable	Not under sanction for new enrollments
Not under sanction for new enrollments	Have capacity (and agree) to accept the enrollments

Special Enrollment Period:
An SEP is available to all individuals who are passively enrolled in addition to the ability to opt-out of a passive enrollment. This SEP allows the individual to make an election before the passive enrollment is effective in the receiving plan or after the coverage in the receiving plan starts. The SEP lasts 3 months beginning from the later of notice of a CMS or State-initiated enrollment action or the enrollment effective date. See §30.4.7 for more details about this SEP.

NOTE: Individuals in non-renewing or terminating plans also have the ability to use other existing SEPs outlined in § 30. Dually-eligible individuals may also have the ability to use the duals SEP to switch plans, provided he or she meets the criteria for that election period (see § 30.4.4 #5). When more than one SEP is available, the individual may use the SEP that provides him or her with the greatest flexibility to choose the plan that best meets his or her needs, but use of one SEP does not negate the availability of other SEPs if the beneficiary chooses to make a subsequent election (provided that the SEP hasn't expired and the individual still meets the SEP qualifying conditions).

20.3.3 - Group Enrollment for Employer or Union Sponsored Plans

CMS is providing a process for group enrollment into an employer/union sponsored MA plan. CMS will allow an employer or union to enroll its retirees using a group enrollment process in which the beneficiaries participate through advance notification and that provides CMS with any information the

employer/union has on other insurance coverage for the purposes of coordination of benefits. MA organizations must adhere to the guidelines outlined in §40.1.6, as well as all other program requirements, in developing and implementing this process.

20.4 - Agreeing to Abide by MA Organization Rules

42 CFR 422.50(a)(6)
Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

To be eligible to elect an MA plan, a beneficiary must be fully informed of and agree to abide by the rules of the MA organization that were provided during the enrollment process (refer to §§ 40.4, 40.4.1, and 40.4.2 regarding what information must be provided to the individual during the enrollment process). "Fully informed" means that the individual must be provided with the applicable rules of the MA organization, as described in §40.4.1 of this chapter, as well as in the Medicare Communications and Marketing Guidelines. The MA organization must deny enrollment to any individual who does not agree to abide by the rules of the MA organization. Agreement to abide by the rules of the MA organization in this context is made through the completion of the enrollment request.

20.5 - Grandfathering of Members on January 1, 1999

An individual who was enrolled on December 31, 1998, in an HMO with a risk contract under §1876 of the Social Security Act was deemed to be enrolled on January 1, 1999, in an MA plan offered by the same organization if he/she did not choose to disenroll from the organization effective on the latter date. This deemed enrollment applied even if the enrollee was not entitled to Medicare Part A or did not live in an MA plan service area or continuation area. The MA organization was not permitted to disenroll such individuals because they were not entitled to Part A, or did not live in the service or continuation area. However, if these individuals elect to disenroll from the MA organization, they are not eligible to enroll in any MA plan until or unless they meet all MA eligibility requirements.

If enrollment in Medicare Part B ends for an individual, the individual may not continue as a member of the MA plan and must be disenrolled as described in §§50.2.2 and 50.6.

The MA organization must identify all Medicare Part B-only "grandfathered" individuals and inform them of their status annually. This notification may be included as part of the Evidence of Coverage. The notice must inform these individuals that if they disenroll from the MA organization, they cannot elect another MA plan unless they become entitled to Medicare Part A (by enrolling in Medicare Part A at SSA and by paying the appropriate premium to CMS) and remain enrolled in Medicare Part B.

MA organizations may continue to provide Part A-equivalent benefits to Medicare Part B-only grandfathered members. In addition, if an MA organization offers Part A-equivalent coverage as a supplemental benefit in an MA plan, then the MA organization may disenroll a Medicare Part B-only grandfathered member who fails to pay the organization's Part A-equivalent premium, just as any member of the MA organization could be disenrolled for nonpayment of premiums (refer to §50.3.1).

Grandfathered members may enroll in other MA plans in the same MA organization (within the same State). However, if grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare), they will not be eligible to enroll in any MA plan in any MA organization until or unless they meet all MA eligibility requirements. If the out-of-area grandfathered members disenroll

from the MA organization (i.e., they switch to Original Medicare or attempt to enroll in another MA organization), they will only be able to enroll in other MA organizations if they meet all MA eligibility requirements, including, but not limited to, that of living in the service area of the MA plan.

20.6 - Eligibility and the Hospice Benefit

An MA organization must not deny enrollment to any individual who has elected the hospice benefit (except in the case of a Medicare MSA plan; see §20.10 for additional eligibility requirements for Medicare MSA plans). Until the MA organization acknowledges that it has received the completed enrollment request and gives a coverage effective date to the individual (refer to Exhibit 4, Exhibit 4a, and §40), the MA organization must not ask any questions related to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered impermissible health screening.

The MA organization may not disenroll any member on the basis of the member electing the hospice benefit either before or after becoming a member of the MA plan.

20.7 - Continuation of Enrollment Option for MA Local Plans

With CMS approval, an MA organization may establish continuation areas, separate and apart from an MA local plan's service area. Refer to Chapter 11 (Medicare Advantage Application Procedures and Contract Requirements) regarding CMS approval of continuation areas. As defined in§10, the CMS-approved continuation area is an additional area outside an MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA plan's members. Members may only choose to continue enrollment with the MA local plan if they have permanently moved from the service area into the continuation area.

As described in Chapter 11, if an MA organization wants to offer a continuation of enrollment option under one or more of the MA local plans it offers, then it must obtain CMS' approval of the continuation area and the marketing materials that describe the continuation of enrollment option. The MA organization must also describe the enrollment option(s) in member materials and make the option available to all members of the MA local plan in question who make a permanent move to the continuation area. An MA organization may require members to give advance notice of their intent to use the continuation of enrollment option. If the MA organization has this requirement, then it must fully describe the required notification process in the CMS-approved marketing materials. In addition, the MA organization must fully explain any continuation option to all potential members of the MA local plan, current members of any other health plan of the MA organization members who reside in the MA local plan service area and/or MA organization continuation area.

If a member who permanently moves from the service area into the continuation area does not choose the continuation of enrollment option when he/she is eligible for the option, then the individual is no longer eligible to be a member of the MA local plan, and the MA organization must initiate the individual's disenrollment. Procedures for continued enrollment are in §60.8 and procedures describing disenrollment for permanent change of residence are described in §50.2.1.

20.8 - Additional Eligibility Requirements for MA Religious Fraternal Benefit (RFB) Plans

An MA RFB plan is a plan that an RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect an MA plan.

20.9 - Eligibility Requirements for Medicare Medical Savings Account (MSA) Plans

There are additional requirements and limitations for individuals who wish to elect a Medicare Medical Savings Account (MSA) plan. An individual is not eligible to elect a Medicare MSA plan if any one of the following applies:

- The individual will reside in the United States for fewer than 183 calendar days during the year in which the enrollment request is effective;
- The individual is enrolled in a Federal Employees Health Benefits program, or is eligible for health care benefits through the Department of Veterans Affairs or the Department of Defense;
- The individual is dual eligible and is entitled to coverage of Medicare premium and/or cost-sharing under a Medicaid State plan;
- The individual is receiving hospice benefits under the Medicare benefit prior to completing the enrollment request; or
- The individual receives health benefits that cover all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, supplemental insurance policies not specifically permitted under 42 CFR 422.104, or retirement health benefits.

20.10 - Additional Eligibility Requirements for Enrollment in MA Special Needs Plans

MA Special Needs Plans (SNP) must limit enrollment to individuals who meet specified eligibility requirements in addition to the eligibility requirements in §20 of this chapter. To be eligible for enrollment in a SNP an individual must meet the eligibility requirements for the specific SNP. Refer to Chapter 16-B of the Medicare Managed Care Manual for additional information regarding special needs plan requirements.

Before processing an enrollment into a dual eligible SNP (D-SNP), the SNP must confirm eligibility, including both MA eligibility and Medicaid eligibility. Acceptable proof of Medicaid eligibility can be a current Medicaid card, a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system. The aforementioned documents or State systems verifications are acceptable proof of Medicaid entitlement for

beneficiaries residing in the 50 states and the District of Columbia. Only where a state Medicaid agency requires a Social Security number to verify Medicaid status may the SNP enrollment request mechanism include a field for this element. An individual's current eligibility for the Medicare Part D Low Income Subsidy (LIS) or any other Medicaid status flag in CMS systems are not acceptable for initial or ongoing Medicaid eligibility verification for the purposes of determining dual eligible SNP eligibility. For current enrollees, the SNP must verify continuing eligibility (e.g. full or partial dual status, as applicable) at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility.

Medicaid subset SNPs may enroll only those dual eligible individuals who meet all applicable MA eligibility requirements and are eligible to enroll in the organization's Medicaid managed care plan, as described in the organization's State contract.

For enrollments into an institutional SNP (I-SNP), the organization must confirm that the individual requires an institutional (skilled nursing facility (SNF), nursing facility (NF), SNF/NF, intermediate care facility for the mentally retarded (ICF/MR) or inpatient psychiatric facility) level-of-care, and that the need for an institutional level-of-care has lasted 90 days or longer. When an institutional SNP opts to enroll special needs individuals prior to a 90 day length-of-stay, the needs-assessment (pre-approved by CMS) must show that the individual's condition makes it likely that the length-of-stay (or need for an institutional level-of-care) will be at least 90 days.

For enrollments into a chronic condition SNP (C-SNP), the organization must contact the provider or provider's office to confirm that the individual has the qualifying condition. The organization must obtain this information in one of the following two ways:

1) Contact the provider or provider's office and obtain verification of the condition prior to enrollment, or

2) Utilize a CMS-approved pre-enrollment qualification assessment tool prior to enrollment and obtain verification of the condition from the provider or provider's office on a post-enrollment basis.

For either method, verification from the provider can be in the form of a note from a provider or the provider's office, or documented telephone contact with the provider or provider's office confirming that the individual has the condition. The organization may need to obtain written permission (separately from the enrollment form) permitting it to contact the beneficiary's provider's office to obtain verification of the condition.

If the organization chooses to use a CMS-approved prequalification assessment tool, it has until the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the severe/chronic disabling condition SNP. If it cannot confirm that the enrollee has the qualifying condition within that time, the organization has the first seven calendar days of the following month (i.e., the second month of enrollment) in which to send the beneficiary notice of his/her disenrollment at the end of that month for not having the qualifying condition. Disenrollment is effective at the end of the second month of enrollment; however, the organization must retain the member if confirmation of the qualifying condition is obtained at any point during the second month of enrollment. In the event the organization submits a disenrollment request to CMS prior to confirming the qualifying condition, a reinstatement request must be submitted to CMS (or its

designee). The beneficiary has an SEP that begins with the month of notification and continues through the two following months to enroll in another MA organization for a prospective effective date. This SEP allows a beneficiary time to find a new plan while reducing the potential for incurring a late enrollment penalty.

> **EXAMPLE:** A beneficiary submits a request to enroll in a SNP effective March 1st. The SNP uses a CMS-approved prequalification assessment tool in February and attempts to confirm the beneficiary's special needs status but is unable to do so by March 31st. Between April 1st and April 7th (inclusive), the SNP must send a notice of prospective disenrollment to the beneficiary indicating April 30th as the disenrollment date. If the beneficiary fails to select a new plan by April 30th, his/her SEP will continue through June 30th. S/he can enroll in a plan effective June 1st or July 1st.

30 - Election Periods and Effective Dates

42 CFR 422.62 & 422.68
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

In order for an MA organization to accept an election, a valid request must be made during an election period (see §10 for the definition of "election"). It is the responsibility of the organization to determine the election period of each enrollment or disenrollment request. To make this determination, the organization may need to contact the individual directly. The plan may incorporate specific statements regarding eligibility of an election period with the enrollment or disenrollment request (see Exhibit 1a for optional use with enrollment mechanisms). However, if this information is not provided with the request, the plan must attempt to contact the individual by phone or other communication mechanism, and determine within the seven (7) day requirement if s/he is eligible to make an election at that time (see Exhibits 5 & 11a). Use of Exhibit 5 for the sole purpose of requesting information regarding an applicant's eligibility for an election period must include a due date that is no later than seven calendar days from the date the enrollment request was received.

Enrollment requests the plan is not denying must be submitted to CMS within seven (7) calendar days of the plan's receipt of the completed enrollment request. (Section 40.3)

Note: An organization's determination about an individual's eligibility for an election period is separate from a determination regarding whether an enrollment/disenrollment request is complete. See Section 40.2.2 for information pertaining to incomplete enrollment requests.

There are six types of election periods during which individuals may make enrollment requests. They are:

- Annual Election Period (AEP);
- Initial Coverage Election Period (ICEP);
- Initial Enrollment Period for Part D (IEP for Part D)[1]
- Open Enrollment Period for Institutionalized Individuals (OEPI)
- Special Election Periods (SEP); and
- Medicare Advantage Open Enrollment Period (MA OEP)

Unless a CMS-approved capacity limit or a CMS-issued enrollment sanction applies, all MA organizations must accept requests to enroll in their MA plans (with the exception of Medicare MSA plans) during the AEP, an ICEP, an IEP for Part D (MA-PD plans only), the MA OEP and any SEP that allows enrollment into the specific plan. (Refer to §30.7 for election periods for Medicare MSA plans.) When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all

[1] For MA, allows enrollment requests for MA-PD plans only.[2] The employer/union establishes criteria for its retirees to participate in the employer/union sponsored MA plan. These criteria are exclusive of and in addition to the eligibility criteria for MA enrollment. Eligibility criteria to participate and receive employer/union sponsored benefits may include spouse/family status, payment to the employer/union of the individual's part of the premium, or other criteria determined by the employer/union.

prospective enrollees (with the exception of reserved vacancies) until the limit is lifted. Refer to §30.9 and §30.9.1 for more information on OEPI plan closures, capacity limits and reserved vacancies.

30.1 - Annual Election Period (AEP)

During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. The last enrollment request made, determined by the application date, will be the enrollment request that takes effect (refer to §60.1 for information on multiple transactions).

Beginning in 2011, the AEP is from October 15 through December 7 of every year. The AEP is also referred to as the "Fall Open Enrollment" season and the "Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage" in Medicare beneficiary publications and other tools. MA organizations may use these descriptions of the AEP in their member materials, as well as in materials for prospective members.

Note: An employer/union sponsored MA plan may have an "open season" as determined by the employer. This may or may not correspond with the *AEP*. Therefore, organizations are not required to accept enrollment requests into employer/union plans during the AEP (unless the AEP and open season occur simultaneously); however, organizations must accept valid requests for disenrollment.

30.2 - Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of:

1. The last day of the month preceding entitlement to both Part A and Part B, or;

2. The last day of the individual's Part B initial enrollment period.

The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. See 42 CFR 407.14 for additional information.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.

EXAMPLES

- Mrs. Donovan's 65th birthday is June 20, 2009. She is eligible for Medicare Part A and Part B beginning June 1, 2009 and has decided to enroll in Part B beginning on June 1. Her ICEP begins on March 1, 2009 and ends on September 30, 2009.

- Mrs. Smith's 65th birthday is April 20, 2008. She is eligible for Medicare Part A and Part B beginning April 1, 2008. Because she is still working and has health insurance provided by her employer, she has decided not to enroll in Part B during her initial enrollment period for Part B. Upon retiring, she will have the opportunity to enroll in Part B (through a Part B SEP). She has

enrolled in Part B effective May 1, 2009. Her ICEP would be February 1 through April 30, 2009.

Please note that the ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must always relate to the individual's entitlement to both Medicare Part A and Part B. When an individual enrolls in an MA-PD plan, s/he has used both the ICEP and the IEP for Part D (see §30.2.1).

30.2.1 - Initial Enrollment Period for Part D (IEP for Part D)

The Initial Enrollment Period for Part D (IEP for Part D) is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when he or she is entitled to Part A OR is enrolled in Part B, AND permanently resides in the service area of a Part D plan. Ultimately, CMS provides a part D eligibility effective date and maintains it in CMS systems.

At the beginning of the Medicare prescription drug coverage program, all current Part D eligible individuals had an IEP for Part D that began on November 15, 2005, and ended on May 15, 2006. During the IEP for Part D, individuals may make one Part D enrollment choice, including enrollment in an MA-PD plan.

Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B. The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. See 42 CFR 407.14 for additional information.

> **EXAMPLE:** Mr. Hackerman's 65th birthday is March 23, 2010. He is currently working, and while he signed up for his Medicare Part A benefits, effective March 1, 2010, he declined his enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, December 2009 – June 2010. Hence, his IEP for Part D is also December 2009 – June 2010.

Individuals not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B have an IEP for Part D that is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for Part D.

> **EXAMPLE:** Mr. Duke lived in Italy at the time of his 65th birthday, which occurred on August 3, 2008. His Part B initial enrollment period began on May 1, 2008, and ended November 30, 2008. He plans to return to the U.S. to reside permanently in June 2010. Since he lived out of the U.S. and was not eligible to enroll in a Part D plan during his IEP for Part B, his initial enrollment period for Part D will occur when he meets all the eligibility requirements for Part D, that is, when he has Part A or B and resides in a Part D plan service area. His IEP for Part D is March 2010 – September 2010.

Individuals eligible for Medicare prior to age 65 (such as for disability) will have another Initial Enrollment Period for Part D based upon attaining age 65.

The ICEP and the IEP for Part D occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and B at first eligibility. Should an individual delay enrollment in Part B to a later time, the ICEP and IEP for Part D become separate with the ICEP changing to then occur as the 3 months immediately preceding entitlement to BOTH parts A and B.

If a Medicare entitlement determination is made retroactively eligibility for Part D begins with the month in which the individual received notification of the retroactive entitlement decision. Therefore, the Part D IEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for three additional months after the month the notice is provided. The effective date is generally the first day of the month after the organization receives a completed enrollment request.

In MA context, the IEP for Part D applies only to MA-PD enrollment requests. Accordingly, when an applicant has both the ICEP and IEP for Part D available to him/her, the organization must submit the transaction to CMS as an IEP for Part D election. Refer to Chapter 3 of the Medicare Prescription Drug Benefit Manual for additional information regarding Part D election periods.

30.3 - Open Enrollment Period for Institutionalized Individuals (OEPI)

The OEPI is continuous for eligible individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution, as defined in §10. The OEPI ends two months after the month the individual moves out of the institution.

> **Special Note for SNP enrollment:** In addition, the OEPI is available for individuals who meet the definition of "institutionalized" to enroll in or disenroll from an MA SNP for institutionalized individuals.

An MA eligible institutionalized individual can make an unlimited number of MA enrollment requests during the OEPI. An MA organization is not required to accept requests to enroll into its plan during the OEPI, but if it is open for these enrollment requests, it must accept all OEPI requests to enroll into the plan.

Since the OEPI is continuous for eligible individuals, Original Medicare is also open continuously. Therefore, MA organizations must accept requests for disenrollment from their MA plans during the OEPI whether or not the MA plan is open to accept enrollment.

Please note the definition of "institution" here differs from that used in determining when an institutionalized full-benefit dual eligible qualifies for the low-income subsidy copayment level of zero.

30.4 - Special Election Period (SEP)

42 CFR 422.62(b)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Special election periods constitute periods outside of the usual IEP, AEP or MA OEP when an individual may elect a plan or change his or her current plan election. As detailed below, there are various types of SEPs, including SEPs for dual eligibles, and for individuals whose current plan

terminates, who change residence and who meet "exceptional conditions" as CMS may provide, consistent with §1851(e)(4) of the Act and §422.62(b) of the MA regulations.

Depending on the nature of the particular special election period, an individual may:

- Discontinue an enrollment in an MA plan and enroll in Original Medicare
- Switch from Original Medicare to an MA plan
- Switch from one MA plan to another MA plan

Certain SEPs are limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time period. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

Note: An individual's eligibility for an SEP provides an opportunity to make an election but does not convey eligibility to enroll in the plan; an individual must also meet all applicable MA eligibility criteria.

It is generally the responsibility of the organization to determine whether the individual is eligible for an SEP. The exception to this determination requirement would be enrollment and disenrollment requests completed or approved by CMS staff. To make this determination, the organization may need to contact the individual directly. The plan may incorporate specific statements regarding eligibility of an SEP with the enrollment or disenrollment request (see Exhibit 1a for optional use with enrollment mechanisms and Exhibit 10a for optional use with disenrollment forms). However, if this information is not provided with the request, the plan must contact the individual to determine if they are eligible to make an election at that time. Unless stated otherwise in this guidance, the organization MUST accept an individual's verbal or written confirmation regarding the conditions that make him or her eligible for the SEP. Determination of eligibility for some SEPs requires that the organization obtain the date on which the individual's circumstances changed (i.e. change in residence, loss of special needs status, etc.). Organizations that obtain this information on the enrollment or disenrollment request are not required to obtain an additional verbal or written confirmation of SEP eligibility.

For enrollment requests obtained during a face-to-face interview or telephone request, the determination of SEP eligibility can be made at that time. For enrollment requests made using paper, or via an electronic enrollment mechanism or the Medicare OEC (without accompanying CMS approval), the organization is not required to contact the applicant to confirm SEP eligibility if the enrollment request includes the applicant's attestation of SEP eligibility.

If SEP eligibility is obtained orally (by phone or in person), the organization must document this contact and retain this information with the enrollment or disenrollment record. If the organization obtains this confirmation through a written notice, such notice must afford the beneficiary the option of calling the organization and confirming this information verbally. If the organization is not able to obtain SEP eligibility information from the applicant, the organization must deny the enrollment or disenrollment request and provide the individual a denial notice (see Exhibit 7).

The following are examples of questions that might be used to determine eligibility for an SEP:

Type of SEP?	Examples of Questions
Change in Residence	Have you recently moved? If so, when? Where did you move from?
Employer/Union Group Health Plan (EGHP)	Do you currently have (or are leaving) coverage offered by an employer or union? Have you recently lost such coverage?
Disenroll from Part D to Enroll in Creditable Coverage	Are you a member of TriCare? Do you have or want to obtain VA benefits?
Full Dual Eligible or Other Low Income Subsidy	Do you currently have Medicaid coverage? Does your state pay for your Medicare premiums? Do you receive SSI cash benefits without Medicaid? Did you receive a letter from Medicare letting you know that you automatically qualify for extra help? How much do you pay for your prescriptions?
Retroactive notice of Medicare entitlement	Have you recently received a notice telling you that you have been approved for Medicare for a "retroactive" date? If so, when did you receive this notice?
PACE	For enrollment – are you currently enrolled in a special plan called "PACE"?
CMS/State Assignment	Have you recently received a blue letter (i.e., Reassignment notice) from Medicare? Did your state/plan send you a letter to let you know they are moving you to a different plan? Did you recently receive a yellow letter (i.e., Auto-enrollment notice) from Medicare? Have you recently received a green letter (i.e., Facilitated Enrollment notice) from Medicare?
Change in Dual/LIS Status	Have you recently gained/lost coverage under Medicaid? Did you recently receive a grey letter (i.e., Loss of Deemed Status notice) from Medicare? Did you recently receive an orange letter (i.e., Change in Extra Help Co-Payment notice) from Medicare? Did you recently receive a purple letter (i.e., Deemed Status notice) from Medicare?

Please note that the time frame of an SEP denotes the time frame during which an individual may make an enrollment or disenrollment request. It does not necessarily correspond to the effective date of coverage. For example, if an SEP exists for an individual from May - July, then an MA organization must receive an enrollment request from that individual sometime between May 1 and July 31 in order to consider the enrollment request an SEP enrollment request. However, the type of SEP will dictate what the effective date of coverage may be.

Individuals who disenroll from an MA plan to Original Medicare during an SEP may be provided Medigap guaranteed issue rights. These rights are not afforded to those individuals who enroll into an MA plan during an SEP. MA organizations are required to notify members of these guaranteed issue rights when members disenroll to Original Medicare during a SEP. See §§50.1.7 and 50.2 for the additional information regarding these notification requirements

The time frames and effective dates for SEPs are discussed in the following sections. SEPs apply to local and regional MA plans unless otherwise specifically stated. Corresponding *Part D* SEPs are provided in separate PDP Enrollment guidance.

30.4.1 - SEPs for Changes in Residence

An SEP for a change in residence exists for these scenarios:

1) individuals who are no longer eligible to be enrolled in an MA plan due to a change in permanent residence outside of the MA plan service area;

2) individuals who were not eligible for MA because they were incarcerated and have now been released, or;

3) individuals who will have new Medicare health or Part D plans available to them as a result of a permanent move.

The SEP permits enrollment elections only; it begins on either the date of the permanent move or on the date the individual provides notification of such move. Since individuals who do not permanently reside in the plan service area are ineligible for the plan and must be disenrolled, a SEP is not needed to effectuate an involuntary disenrollment for that reason (see §50.2.1). Individuals who move and have new Medicare health or Part D plans available to them as a result of the move, but continue to reside in the current plan service area, may use this SEP to enroll in any MA or Part D plan for which they are eligible in their new place of residence. It is the individual's responsibility to notify the MA organization that he/she is permanently moving.

When the individual notifies the organization of a permanent move out of the plan service area, the SEP begins either the month before the individual's permanent move, if the individual notifies the organization in advance, or the month the individual provides the notice of the move, if the individual has already moved. The SEP continues for two months following the month it begins or the two months following the month of the move, whichever is later.

If the organization learns from CMS or another source (as described in §50.2.1.3) that the individual has been out of the service area for over six months and the organization has not been able to confirm otherwise with the individual, the SEP starts at the beginning of the sixth month and continues through to the end of the eighth month.

The enrollment effective date is determined by the date the MA organization receives the enrollment request**.** The individual may choose an effective date of up to three months after the month in which the MA organization receives the enrollment request. However, the effective date may not be earlier than the date the individual moves to the new service area and the MA organization receives the enrollment request.

EXAMPLE 1

A beneficiary is a member of an MA plan in Florida and intends to move to Arizona on June 18. A SEP exists for this beneficiary from May 1 - August 31.

A. If an MA organization in Arizona receives an enrollment request from the beneficiary in May, the beneficiary can choose an effective date of July 1, August 1, or September 1.

B. If the MA organization receives the enrollment request from the beneficiary in June (the month of the move), the beneficiary can choose an effective date of July 1, August 1, or September 1.

C. If the MA organization receives the enrollment request in July, the beneficiary could choose an effective date of August 1, September 1, or October 1.

EXAMPLE 2

A beneficiary resides in Florida and is currently in Original Medicare and not enrolled in an MA plan. The individual intends to move to Maryland on August 3. An SEP exists for this beneficiary from July 1 through October 31.

At the time the individual makes the enrollment request into an MA plan, the individual must provide the specific address where the individual will permanently reside upon moving into the service area, so that the MA organization can determine that the individual meets the residency requirements for enrollment in the plan.

Disenrollment from Previous MA Plan

Please keep in mind that a member of an MA plan who moves permanently out of the service area must be involuntarily disenrolled from the plan, unless continuation of enrollment applies. A member of an MA plan who is out of the service area for *more than* six months must be involuntarily disenrolled from the plan.

CMS has established an SEP that allows an individual adequate time to choose a new MA plan, given the fact that the individual will no longer be enrolled in the original MA plan after the month of the move or after the sixth month (whichever is appropriate). Unless an individual enrolls in a new MA plan with an effective date of the month after the move or the beginning of the seventh month (e.g., the individual moves on June 18 and enrolls in a new plan effective July 1), he/she will be enrolled in Original Medicare until he/she elects the new MA plan during a valid enrollment period. If the individual had Part D coverage and lost it due to the involuntary disenrollment, s/he may be subject to a Part D late enrollment penalty (LEP). See Chapter 4 of the Medicare Prescription Drug Manual for more information.

30.4.2 - SEPs for Contract Violation

In the event an individual is able to demonstrate to CMS that the MA organization offering the MA plan of which he/she is a member substantially violated a material provision of its contract under MA in relation to the individual, or the MA organization (or its agent) materially misrepresented the plan when marketing the plan, the individual may disenroll from the MA plan and elect Original Medicare

or another MA plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately elects a new MA plan upon disenrollment from the original MA plan or whether the individual initially elects Original Medicare before choosing a new MA plan.

We note that in some case-specific situations, CMS may process a retroactive disenrollment for these types of disenrollments. If the disenrollment is not retroactive:

- A SEP exists such that an individual may elect another MA plan or Original Medicare during the last month of enrollment in the MA organization, for an effective date of the month after the month the new MA organization receives the enrollment request.

  EXAMPLE

  On January 16, CMS determines, based on a member's allegations, that the MA organization substantially violated a material provision of its contract. As a result, the member will be disenrolled from the MA plan on January 31. A SEP exists for this beneficiary beginning January 16 and lasting until the end of January. The beneficiary promptly applies for a new MA plan, and the new MA organization receives the enrollment form on January 28 for a February 1 effective date.

- If the individual in the above example elected Original Medicare during the last month of enrollment in the MA organization (either by choosing Original Medicare or by not choosing an MA plan and therefore defaulting to Original Medicare), the individual will be given an additional 90 calendar days from the effective date of the disenrollment from the MA organization to elect another MA plan. During this 90-day period, and until the individual elects a new MA plan, the individual will be enrolled in Original Medicare. The individual may choose an effective date into a new MA plan beginning any of the three months after the month in which the MA organization receives the enrollment request. However, the effective date may not be earlier than the date the MA organization receives the enrollment request.

  EXAMPLE

  On January 16, CMS determines, based on a member's allegations that the MA organization substantially violated a material provision of its contract. The member decides to return to Original Medicare. As a result, the member is disenrolled from the MA plan on January 31 and enrolled in Original Medicare with a February 1 effective date. A 90-day SEP continues to exist for the beneficiary from February 1 through April 30. In this example, a new MA organization then receives an enrollment request from the individual on April 15. The beneficiary can choose an effective date of May 1, June 1, or July 1.

If the disenrollment is retroactive, CMS will provide the beneficiary with the time frame for his/her SEP to elect another plan on a case-by-case basis. Depending on the circumstances surrounding the contract violation, CMS may determine a retroactive enrollment into another MA plan is warranted.

30.4.3 - SEPs for Non-renewals or Terminations

In general, SEPs are established to allow members affected by non-renewals or terminations ample time to elect a new plan. Effective dates during these SEPs are described below. CMS has the

discretion to modify this SEP as necessary for any non-renewals or terminations when the circumstances are unique and warrant a modified SEP.

- **Non-renewals -** A SEP exists for members of MA plans that will be affected by plan or contract non-renewals and plan service area reductions that are effective January 1 of the contract year. In order to provide sufficient time for members to evaluate their options, the SEP begins December 8 and ends on the last day in February of the following year.

  Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January will have an effective date of February 1. Enrollment requests received in February will have an effective date of March 1.

- **MA organization Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** A SEP exists for members of plans who will be affected by a termination of contract by the MA organization or a modification or termination of the contract by mutual consent (42 CFR §§422.512 and 422.508(a)(1)). The SEP begins two months before the proposed termination effective date, and ends one month after the month in which the termination occurs.

  Please note that if an individual does not elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a current, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may request an effective date of the month after notice is given, or up to two months after the effective date of the termination. However, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

  EXAMPLE

  If an MA organization contract terminates for cause on April 30, an SEP lasts from March 1 through May 31. In this scenario, a beneficiary could choose an effective date of April 1, May 1, or June 1; however, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

- **CMS Termination of MA organization Contract -** A SEP exists for members of plans that will be affected by MA organization contract terminations by CMS (42 CFR 422.510). The SEP begins 1 month before the termination effective date and ends 2 months after the effective date of the termination.

  Please note that if an individual does not elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for two months after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a current, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may select an effective date of up to three months after the month of termination. However, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

EXAMPLE

If CMS terminates an MA organization contract effective June 30, an SEP lasts from June 1 through August 31. In this scenario, a beneficiary could choose an effective date of July 1, August 1, or September 1; however, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (*42 CFR* 422.510(b)(2)), where CMS provides notice of termination to an MA plan's members and the termination may be mid-month.

Note: Approved plan consolidations are neither terminations nor non-renewals. Thus individuals affected by plan consolidations are not eligible for the SEP for non-renewals or terminations. Please see the annual CMS Call Letter and other CMS end-of-year guidance for more information about approved plan consolidations.

30.4.4 - SEPs for Exceptional Conditions

42 CFR 422.62(b)(4)
(Rev. *2*, Issued: *August 12, 2020*; Effective/Implementation: 01-01-20*21*)

CMS has the legal authority to establish SEPs when an individual or group of individuals meets exceptional conditions specified by CMS, including on a case-by-case basis. The SEPs CMS has established include:

1. SEP EGHP (Employer/Union Group Health Plan)
42 CFR 422.62(b)(4)

An SEP exists for individuals making MA enrollment requests into or out of employer sponsored MA plans, for individuals to disenroll from an MA plan to take employer sponsored coverage of any kind, and for individuals disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan. The SEP EGHP may be used when the EGHP allows the individual to make changes in their health coverage choices, such as during the employer's or union's "open season," or at other times the employer or union allows. This SEP is available to individuals who have (or are enrolling in) an employer or union sponsored plan and ends 2 months after the month the employer or union coverage ends.

The individual may choose an effective date of up to three months after the month in which the individual completed an enrollment or disenrollment request; however, the effective date may not be earlier than the first of the month following the month in which the request was made. The effective date also may not be earlier than the first day of the individual's entitlement to both Medicare Part A and Part B.

NOTE: If necessary *due to the employer's or union's delay in forwarding the completed enrollment request to the MA organization*, the MA organization may process the enrollment request with a retroactive effective date, as outlined in §60.6. Keep in mind that all MA eligible individuals, including those in EGHPs, may elect MA plans during the AEP and ICEP and during any other SEP. The SEP EGHP does not eliminate the right of these individuals to make enrollment requests during these *election periods*.

Refer to §30.6 for additional information for situations in which an individual is determined eligible for more than one election period, one of which includes the SEP EGHP.

2. SEP for Individuals Who Disenroll in Connection with a CMS Sanction
42 CFR 422.62(b)(5)

On a case by case basis, CMS will establish an SEP *for individuals enrolled in an MA plan offered by* an MA organization *that has been sanctioned by CMS who elect to* disenroll in connection with the matter that gave rise to that sanction. The start/length of the SEP, as well as the effective date, is dependent upon the situation. *The SEP starts with the imposition of the sanction and ends when the sanction ends or when the individual makes an election, whichever occurs first.*

CMS may require the MA organization to notify current enrollees that if the enrollees believe they are affected by the matter(s) that gave rise to the sanction, the enrollees are eligible for a SEP to elect another MA plan or disenroll to original Medicare and enroll in a PDP.

3. SEP for Individuals Enrolled in Cost Plans that are Non-renewing their Contracts
42 CFR 422.62(b)(6)

An SEP will be available to Medicare beneficiaries who are enrolled *in an* HMO or CMP under a §1876 cost contract that will no longer be offered in the area in which the beneficiary *resides*. Beneficiaries electing to enroll in an MA plan via this SEP must meet MA eligibility requirements.

This SEP begins December 8 of the current contract year and ends on the last day of February of the following year.

Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January will have an effective date of February 1. Enrollment requests received in February will have an effective date of March 1.

4. SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE)
42 CFR 422.62(b)(7)

Individuals may disenroll from an MA plan at any time in order to enroll in PACE. In addition, individuals who disenroll from PACE have an SEP *to elect an MA plan. The SEP ends* 2 months after the effective date of PACE disenrollment.

5. SEP for Dual-eligible Individuals and Other LIS-Eligible Individuals–
42 CFR 423.38(c)(4)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

There is an SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g. QMB-only, SLMB-only, etc.) and individuals who qualify for LIS (but who do not receive Medicaid benefits).

This SEP begins the month the individual becomes dually-eligible and exists as long as he or she receives Medicaid benefits; however there are limits in how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:

- January – March,
- April – June, and
- July – September.

It may not be used in the 4th quarter of the year (October – December).

The SEP is considered "used" based on the month in which the individual makes the election (i.e., application date of the enrollment request). If the plan receives an election in March (which would be effective April 1st), this counts as "using" the SEP for the 1st quarter, not the 2nd quarter.

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

NOTES:

- As described in § 40.1.5, the effective date for auto-enrollments of full-benefit dual-eligible individuals may be retroactive.
- Organizations need to check for prior uses of the SEP via the BEQ or MARx UI to determine eligibility.
- CMS will reject enrollment transactions for individuals who have already used this SEP in the calendar quarter.

Use of this SEP is separate from, and in addition to, the SEPs outlined in #12 in this section (SEP for Individuals who Lose or Have a Change in their Dual or LIS-Eligible Status) and § 30.4.7 (SEP for Individuals Who Have Been Enrolled into a Plan by CMS or the State). If a dual or other-LIS eligible beneficiary is making an election and is also eligible for another SEP, the organization should use the other SEP instead of this SEP.

Limitation for "At-Risk" and "Potential At-Risk" Beneficiaries:
Once an individual is identified by the MA-PD organization as a "potential at-risk" or "at-risk" beneficiary and the plan sponsor has sent written notice to the individual, he or she cannot use this SEP to change plans while this designation is in place. The notice to the individual explains that this SEP is no longer available. Additional information on drug management programs is available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html

Duration of Limitation – This limitation starts as of the date on the initial notice provided to the "potential at-risk" beneficiary. The chart below outlines when the limitation ends:

Situation	SEP limitation ends
Plan decides not to identify the "potential at-risk" beneficiary as an "at-risk" beneficiary	60 days from the date on the initial notice, or the date the beneficiary receives notice of the plan's decision, if earlier.
The "potential at-risk" or "at-risk" beneficiary identification is subsequently removed by the	The date that the designation is removed by the plan or upon effectuation of a favorable appeal

Situation	SEP limitation ends
plan or through beneficiary's favorable appeal of an "at-risk" determination	
The plan determines the beneficiary is "at-risk"	12 months from the date the individual is determined to be "at-risk"
The plan extends the "at-risk" designation beyond the initial 12 months	24 months from the date the individual is determined to be "at-risk" **NOTE:** This is the maximum consecutive time the SEP limitation can be imposed for each "at-risk" limitation a sponsor implements.

The limitation ends based on whichever situation occurs first. If a plan sponsor removes the individual's status as an "at-risk" beneficiary or the designation expires, the plan may subsequently determine that the individual is "potentially at-risk" again, in accordance with the requirements for drug management programs in *42 CFR* 423.153(f)(1). Consequently, the SEP would, once again, not be available to the individual based on the date the plan sends the new notification. For more information on "potentially at-risk" or "at-risk" designations, see www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html.

NOTE: Organizations need to check for this designation via the BEQ or MARx UI to determine eligibility. The enrollment limitation for a "potential at-risk" or an "at-risk" individual will not apply to other Part D enrollment periods, including the AEP or other SEPs.

6. SEP for Individuals Who *Terminated* a Medigap Policy When They Enrolled For the First Time in an MA Plan, and Who Are Still in a "Trial Period"
42 CFR 422.62(b)(8)

For Medicare beneficiaries who *terminated* a Medigap policy when they enrolled for the first time in an MA plan, §1882(s)(3)(B)(v) of the Act provides a guaranteed right to purchase another Medigap policy if they disenroll from the MA plan while they are still in a "trial period." In most cases, a trial period lasts for 12 months after a person enrolls in an MA plan for the first time.

This SEP *is* for individuals who are eligible for "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act upon disenrollment from the MA plan in which they are enrolled. This SEP allows a qualified individual to make a one-time election to disenroll from their first MA plan to join Original Medicare at any time of the year. The SEP begins upon enrollment in the MA plan and ends after 12 months of enrollment or when the beneficiary disenrolls *from the MA plan*, whichever is earlier.

7. SEP for Individuals with ESRD Whose Entitlement Determination Made Retroactively
42 CFR 422.62(b)(9)

If a Medicare entitlement determination is made *for a* retroactive *effective date*, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to elect an MA plan *for a prospective effective date*.

This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have

his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period AFTER dialysis begins.

The SEP begins the month the individual receives the notice of the *retroactive* Medicare entitlement determination and continues for 2 additional *calendar* months after the month the notice is received. The enrollment effective date is the first day of the month after the MA plan receives the enrollment request. *This SEP is not available after December 31, 2020.*

8. SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively
42 CFR 422.62(b)(10)

If a Medicare entitlement determination is made *for a* retroactive *effective date*, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to elect an MA plan *for a prospective effective date*. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely by SSA and/or received by the individual in a timely manner.

The SEP begins the month the individual receives the notice of the *retroactive* Medicare entitlement determination and continues for two additional *calendar* months after the month the notice is received. The effective date *is the first day of the month after the MA plan receives the enrollment request*.

9. MA SEPs to Coordinate With Part D Enrollment Periods – Individuals eligible for an enrollment period under the guidance for Part D enrollment and disenrollment may use that SEP to make an election into or out of an MA-PD plan (as applicable). Most Part D SEPs are duplicated in the MA program as described above; however, those that are not described elsewhere are provided here:

A. Involuntary loss of creditable coverage, including a reduction in the level of coverage so that it is no longer creditable, not including any such loss or reduction due to a failure to pay premiums. The SEP permits enrollment into a*n MA-PD* and begins *when* the individual is advised of the loss of *(or reduction in)* creditable coverage*. The SEP* ends two *calendar* months after either the loss (or reduction) occurs or the individual received notice, whichever is later. The effective date of this SEP *is* the first of the month after the *election is made* or, at the beneficiary's request, may be *up to 3 months* prospective. *(42 CFR 422.62(b)(19))*

B. Individuals who are not adequately informed of a loss of creditable coverage, or that they never had creditable coverage, have an SEP *that* permits one enrollment in, or disenrollment from, a*n MA-PD* plan*. CMS determines eligibility for this* on a case-by-case basis*, based on its determination that an entity offering prescription drug coverage failed to provide accurate and timely disclosure of the loss of creditable prescription drug coverage or whether the prescription drug coverage offered is creditable*. This SEP begins the month of CMS approval of this SEP and continues for two additional *calendar* months following this approval. *(42 CFR 422.62(b)(20))*

C. Individuals whose enrollment or non-enrollment in a Part D plan is erroneous due to an action, inaction or error by a Federal Employee. The SEP permits disenrollment and/or enrollment in a Part D plan on a case-by-case basis. Requests for this SEP must be developed and presented to the CMS Regional Office serving the MA-PD plan for which the SEP will apply. This SEP begins the month of CMS approval of this SEP and continues for two additional months following this approval. *(42 CFR 422.62(b)(21))*

D. An individual eligible for an additional Part D IEP, such as an individual currently entitled to Medicare due to a disability and who is attaining age 65, has an MA SEP to coordinate with the additional Part D IEP. The SEP may be used to disenroll from an MA-only or MA-PD plan to Original Medicare, or to enroll in an MA-only plan (regardless of whether the individual uses the Part D IEP to enroll in a PDP). The SEP begins and ends concurrently with the additional Part D IEP. *(42 CFR 422.62(b)(22))*

For more information about PDP enrollment and disenrollment, please refer to the CMS guidance for PDPs.

10. SEP for Individuals Who Lose Special Needs Status
42 CFR 422.62(b)(11)

CMS will provide an SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status. This SEP begins *the month the individual's special needs status changes* and ends when *he or she* makes an enrollment request or three *calendar* months after the *effective date of involuntary disenrollment from the SNP, whichever is earlier*.

11. SEP for Individuals Who Belong to a Qualified SPAP or Who Lose SPAP Eligibility
42 CFR 422.62(b)(12)

Individuals who belong to a qualified State Pharmaceutical Assistance Program (SPAP) are eligible for an SEP to *request* enrollment *in an MA-PD plan* at any time through the end of each calendar year (i.e. once per year). SPAP members may use this SEP to enroll in a Part D plan outside of existing enrollment opportunities, allowing them, for example, to join a*n MA-PD* plan upon becoming a member of an SPAP or to switch to another *MA-PD* plan. In summary, a beneficiary may use this SEP to switch from an MA-PD plan to another MA-PD plan, from Original Medicare without a PDP to an MA-PD plan, from a PDP to another PDP or MA-PD plan or from an MA-only plan (no prescription drug coverage) to a*n* MA-PD plan. *This SEP is available while the individual is enrolled in the SPAP and, upon loss of eligibility for SPAP benefits, for an additional 2 calendar months after either the month of the loss of eligibility or notification of the loss, whichever is later*.

12. SEP for Individuals who Gain, Lose, or Have a Change in their Dual or LIS-Eligible Status–
42 CFR 423.38(c)(9)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

An SEP is provided for individuals who receive "Extra Help." It includes those who:

- Become eligible for any type of assistance from the Title XIX program (including "partial duals" who receive cost sharing assistance under Medicaid) and individuals who qualify for LIS (but who do not receive Medicaid benefits);
- Lose eligibility for any type of assistance; and
- Have a change in the level of assistance they receive (e.g., stop receiving Medicaid benefits, but still qualify for LIS, those who have a change in cost sharing*, or become eligible for additional Medicaid benefits [e.g., when an individual newly qualifies as needing nursing home level of care and thus becomes eligible for certain Medicaid long term supports and services, or becomes eligible for full Medicaid after having previously been eligible for Medicaid coverage of Medicare premiums or cost-sharing]*).

The SEP allows the individual one opportunity to make an election within three months of any of the changes noted above, or notification of such a change, whichever is later. The effective date for enrollments under this SEP is the first day of the month following receipt of the enrollment request by the plan.

NOTE: Use of this SEP does not count towards the once per calendar quarter limitation outlined in SEP #5 in this section.

13. SEP for Enrollment Into a Chronic Care SNP and for Individuals Found Ineligible for a Chronic Care SNP
42 CFR 422.62(b)(13)

CMS will provide an SEP for those individuals with severe or disabling chronic conditions to enroll in a SNP designed to serve individuals with those conditions. This SEP *is available while* the individual has the qualifying condition*(s); it ends upon enrollment in the chronic care* SNP. Once the SEP ends, that individual may make enrollment changes only during applicable MA election periods. In addition, individuals enrolled in a Chronic Care SNP who have a severe/disabling chronic condition which is not a focus of their current SNP are eligible for this SEP. Such individuals have an opportunity to enroll in a Chronic Care SNP that focuses on this other condition. Eligibility for this SEP ends at the time the individual enrolls in the new SNP.

Individuals who are found after enrollment not to have the qualifying condition necessary to enroll in a Chronic Care SNP will have an SEP to enroll in a different MA-PD plan or an MA-only plan with accompanying Part D coverage. This would normally occur when the required post enrollment verification with a provider did not confirm the information provided on the pre-enrollment assessment tool. This SEP begins when the plan notifies the individual of the lack of eligibility and extends through the end of that month as well as the following two *calendar* months. The SEP ends when the individual makes an enrollment election or on the last day of the second of the two *calendar* months following notification. Any enrollments made during this election period are for prospective effective dates.

14. SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage
42 CFR 422.62(b)(14)

Individuals may disenroll from a*n* MA-PD *plan*) to enroll in or maintain other creditable drug coverage (such as TriCare or VA coverage). The effective date of disenrollment is the first day of the month following the month a disenrollment request is received by the *MA organization*. Additionally, individuals enrolled in an MA-PD plan who have or are enrolling in other creditable coverage may use this SEP to disenroll from the MA-PD plan by enrolling in an MA-only plan.

15. SEP to Enroll in an MA Plan, PDP or Cost Plan With a Plan Performance Rating of Five (5) Stars
42 CFR 422.62(b)(15)

An eligible individual may enroll in an MA plan *offered by an MA organization with a Star Rating* of 5 *S*tars during the year in which that plan has the 5-star overall *performance* rating, provided the enrollee meets the other requirements to enroll in that plan (e.g., living within the service area).

Individuals may use the 5-Star SEP to disenroll from a Medicare Advantage plan by enrolling in a 5-Star cost plan that is open for enrollment.

As overall ratings are assigned for the plan contract year (January through December), possible enrollment effective dates are the first of the month from January 1 to December 1 during the year for which the plan has been assigned an overall *performance* rating of 5 stars. An individual may use this SEP only one time from December 8 through November 30 of the following year in which the organization has been granted a 5-star overall rating. The enrollment effective date is the first of the month following the month in which the plan receives the enrollment request.

> **EXAMPLE:** Plan X has an overall rating of 4.5 stars in 20*20* and 5 stars for 20*21*. An individual could use this SEP to request enrollment in Plan X *beginning* December 8, 20*20* for an effective date of January 1, 20*21*. An individual could not use the SEP to enroll in Plan X for an effective date on or before December 1, 20*20*, as the enrollment effective dates available during that period are prior to the calendar year for which Plan X has been assigned a 5-star overall rating.

> **EXAMPLE:** Plan Y has an overall rating of 5 stars for 20*20* but has lost that 5-star rating for 20*21*. A beneficiary could use this SEP to request enrollment in Plan Y for the first of the following month until November 30, 20*20*, with the last possible effective date available being December 1, 20*20*. The beneficiary could not use the SEP to enroll in Plan Y on or after December 1, 20*20*, as the enrollment effective dates available during that period are after the calendar year for which Plan Y has been assigned a 5-star overall rating.

An individual using this SEP can enroll in an MA-only *or* an MA-PD plan, even if coming from Original Medicare (with or without concurrent enrollment in a PDP). Individuals enrolled in a plan with a 5-star overall rating may also switch to a different plan with a 5-star overall rating. An individual in an MA-only or MA-PD coordinated care plan who switches to a PDP with a 5-star overall rating will lose MA coverage and will revert to Original Medicare for basic medical coverage.

Regardless of whether the individual has Part D coverage prior to use of this SEP, any individual who enrolls in a 5-star M*A Private* Fee-for-Service plan without prescription drug coverage or a 5-star cost plan is eligible for *a* coordinating Part D SEP to enroll in a PDP. (See Chapter 3, Section 30.3.8 #8, letter H*,* of the Medicare Prescription Drug Benefit Manual for more information.)

Note that use of this SEP does not guarantee Part D coverage. If an individual in either an MA-PD plan or a PDP chooses to enroll in an MA-only coordinated care plan with a 5-star overall rating, that individual would lose Part D coverage and must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Late enrollment penalties might also apply.

Individuals may use the 5-Star SEP to disenroll from an MA plan by enrolling in a 5-Star cost plan that is open for enrollment.

> ***EXAMPLE:** A cost plan has an overall rating of 5 stars for 2020 and is open for enrollment. An individual enrolled in a MA plan uses this SEP to enroll in the cost plan. The cost plan submits the enrollment transaction to MARx using the "R" election type code, and the MA plan accepts and processes the subsequent disenrollment per the Daily Transaction Reply Report (DTRR).*

16. SEP for Non-U.S. Citizens who become Lawfully Present
42 CFR 422.62(b)(16)

CMS will provide an SEP for non-U.S. citizens who become lawfully present in the United States. The individual may use this SEP to request enrollment in any MA plan for which he or she is eligible, including an MA-PD. This SEP begins the month the *individual attains* lawful presence starts and ends *the earlier of* when the individual makes an enrollment request or two (2) full calendar months after the month it begins.

17. SEP for Providing Individuals who Requested Materials in Accessible Formats Equal Time to Make Enrollment Decisions
42 CFR 422.62(b)(17)
(Rev. *2*, Issued: August , *2020*; Effective/Implementation: 01-01-20*21*)

As outlined in Section 504 of the Rehabilitation Act of 1973 (Section 504), organizations are required to comply with its requirements, and provide materials in accessible formats to its members. This generally includes formats such as Braille, Data, and Audio files, or other formats accepted by the member in place of, or in addition to, the original print material.

A SEP *is available to an individual who was adversely affected by having requested, but not received,* required notices or information in an accessible format within the same timeframe that *the MA organization or CMS* provide*d* the same information to individuals who did not request an accessible format. This limited SEP ensures that beneficiaries who have requested information in accessible formats are not disadvantaged by any additional time necessary to fulfill their request, including missing an election period deadline.

The SEP begins at the end of the election period during which the beneficiary was seeking to make an election. The length of the SEP *is* at least as long as the time it took for the information to be provided to the individual in an accessible format. Organizations may *determine eligibility for* this SEP when the *criterion is* met, ensuring adequate documentation of the situation*, including* records indicating the amount of time taken to provide accessible versions of *the requested* materials *and the amount of time it takes for the same information to be provided to an individual who does not request an accessible format*. Individuals seeking assistance for this SEP may also contact 1-800-MEDICARE.

18. SEP for *Government Entity*-Declared *Disaster* or *Other* Emergency
42 CFR 422.62(b)(*18*)
(Rev. *2*, Issued: *August 12*, *2020*; Effective/Implementation: 07-30-20*21*)

A SEP exists for individuals affected by a *disaster or other* emergency *declared by a Federal, state or local government entity* who were unable to, and did not make an election during another valid election period. This includes both enrollment and disenrollment elections. Individuals *are* eligible for this SEP if they:

- Reside, or resided at the start of the *SEP eligibility* period *described in this guidance*, in an area for which *a federal, state or local government entity* has declared *a disaster or other* emergency or *they do not reside in an affected area but rely on help making healthcare decisions from one or more individuals who reside in an affected area*; *and*
- *Were eligible for* another election period at the time of *the SEP eligibility* period; and

- Did not make an election during that other valid election period *due to the disaster or other emergency*.

The SEP *starts as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier. The SEP ends 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later*.

19. SEP for Individuals Enrolled in a Plan Placed in Receivership

42 CFR 422.62(b)(24)

A SEP exists for individuals enrolled in a plan offered by an MA organization that has been placed into receivership by a state or territorial regulatory authority.

The SEP begins the month the receivership is effective and continues until it is no longer in effect or until the enrollee makes an election, whichever occurs first. When instructed by CMS, the MA plan that has been placed under receivership must notify its enrollees, in the form and manner directed by CMS,of the enrollees' eligibility for this SEP and how to use the SEP.

20. SEP for Individuals Enrolled in a Plan That Has Been Identified by CMS as a Consistent Poor Performer

42 CFR 422.62(b)(25)

A SEP exists for individuals enrolled in a plan that has been identified with the low performing icon in accordance with 42 CFR 422.166(h)(1)(ii). This SEP exists while the individual is enrolled in the low performing MA plan.

21. SEP for Other Exceptional Circumstances

422.62(b)(26)

CMS will establish a SEP, on a case by case basis, for individuals whom CMS determines have experienced exceptional circumstances related to enrollments into or disenrollments from an MA plan that are not otherwise captured in regulation. Consistent with current practice, CMS will consider granting an enrollment or disenrollment opportunity in situations such as the following:

- *Circumstances beyond the beneficiary's control that prevented him or her from submitting a timely request to enroll or disenroll from a plan during a valid election period. This is inclusive of, but not limited to, a serious medical emergency of the beneficiary or his or her authorized representative during an entire election period, a change in hospice status, or mailed enrollment or disenrollment requests returned as undeliverable on or after the last day of an enrollment period.*
- *Situations in which a beneficiary provides a verbal or written allegation that his or her enrollment in a MA or Part D plan was based upon misleading or incorrect information provided by a plan representative or State Health Insurance Assistance Program (SHIP) counselor, including situations where a beneficiary states that he or she was enrolled into a plan without his or her knowledge or consent, and requests cancellation of the enrollment or disenrollment from the plan.*

- *A SEP may be warranted to ensure beneficiary access to services and where without the approval of an enrollment exception, there could be adverse health consequences for the beneficiary. This is inclusive of, but not limited to, maintaining continuity of care for a chronic condition and preventing an interruption in treatment.*

CMS will review supporting details and documentation to determine eligibility for the SEP for exceptional circumstances. CMS's review can be in response to an individual beneficiary's request for an exception to the current enrollment rules, as well as CMS' determination that an exception is warranted for a group of beneficiaries.

The SEP would take effect once CMS makes its determination and the enrollee has been notified. The effective date for an enrollment or disenrollment election using an approved enrollment exception would be based on the beneficiary's circumstances and may be either prospective or retroactive.

30.4.5 - SEPs for Beneficiaries Age 65 (SEP65)

MA eligible individuals who elect an MA plan (other than an MSA plan) during the initial enrollment period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from this MA plan and elect the Original Medicare plan any time during the 12-month period that begins on the effective date of coverage in the MA plan.

The IEP for Part B is established by Medicare and begins 3 months before and ends 3 months after the month of the individual's 65th birthday. Individuals entitled to Medicare prior to age 65 are not eligible for the SEP65.

30.4.6 – SEP for Significant Change in Provider Network

42 CFR 422.62(b)(23)
(Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

CMS will establish a SEP, on a case by case basis, for situations in which CMS determines that changes to an MA plan's provider network are significant based on the affect*,* or potential to affect, current plan enrollees *who are assigned to, are currently receiving care from, or who have received care within the past 3 months* from *a provider or facility being terminated from the provider network*.

The *can be used only once per significant change in provider network. It begins the month* enrollees *are* notified *of eligibility for the SEP* and continues for an additional two *calendar* months *thereafter*.

30.4.7 – SEP for CMS and State-Initiated Enrollments

42 CFR 422.60(g)(5) and 423.38(c)(10)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Individuals who are enrolled into a plan by CMS or a State (i.e., through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment) have an SEP to disenroll from their new plan or enroll into a different plan. The SEP permits a onetime election within three months of the effective date of the assignment, or notification of the assignment, whichever is later. It allows the individual to make an election before the enrollment is effective in the receiving plan or after the coverage in the receiving plan starts. This SEP must be used within three months of the start of coverage in the

receiving plan. In the case where the notice is sent after the coverage in the receiving plan starts, the SEP ends three months after the date of the notice. This SEP is provided so that an individual may exercise any mandatory "opt-out" right provided to the enrollee as part of the CMS or State-initiated enrollment.

The effective date for enrollments under this SEP is the first day of the month following receipt of the enrollment request by the plan.

Individuals passively enrolled due to a plan's non-renewal or termination (outlined in § 20.4.2) may also be eligible for an SEP as outlined in § 30.4.3 of this Chapter.

30.5 – Medicare Advantage Open Enrollment Period (MA OEP)

42 CFR 422.62(a)(3)
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

During the MA OEP, MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP.

This chart outlines who can use the MA OEP and when:

Who can use the MA OEP:	**MA OEP occurs:**
Individuals enrolled in *an* MA plan	January 1 – March 31
New Medicare beneficiaries who are enrolled in an MA plan during their ICEP	The month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement

Individuals *enrolled in an MA plan* may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to:

- MA-PD
- MA-only
- Original Medicare (with or without a stand-alone Part D plan)

The effective date for an MA OEP election is the first of the month following receipt of the enrollment request.

NOTE: The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan. It also does not allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. The MA OEP is not available for those enrolled in Medicare Savings Accounts or other Medicare health plan types (such as cost plans or PACE).

30.6 - Effective Date of Coverage

42 CFR 422.68(c)
(Rev. *2*, Issued: *August 12,* 20*21*; Effective/Implementation: 01-01-20*21*)

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their enrollment effective date. Furthermore, except for EGHP enrollment requests, the

effective date is generally not prior to the receipt of an enrollment request by the MA organization. An enrollment cannot be effective prior to the date the beneficiary or his/her legal representative *completed* the enrollment request. The effective date may not be earlier than the first day of the individual's entitlement to both Medicare Part A and Part B. *§40.2 includes procedures for handling situations when a beneficiary chooses an unallowable enrollment effective date.*

To determine the proper effective date, the MA organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the enrollment request is received by the MA organization.

Once the election period is identified by the MA organization, the MA organization must determine the effective date. Refer to §60.8 to determine the effective date for a continuation of enrollment. In *certain circumstances*, EGHP enrollments may be retroactive (refer to §60.6 for more information on EGHP retroactive effective dates).

Effective dates are as follows:

Election Period	Effective Date of Coverage	Do MA organizations have to accept enrollment requests in this election period?
Initial Coverage Election Period and Initial Enrollment Period for Part D	First day of the month of entitlement to Medicare Part A and Part B – or- The first of the month following the month the enrollment request was made if after entitlement has occurred.	Yes – unless capacity limit applies (see §30.9 for capacity limit information). IEP for Part D is applicable only to MA-PD enrollment requests.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request	No - the MA organization can choose to be "open" or "closed" for enrollments during this period.
Annual Election Period	January 1 of the following year	Yes – unless capacity limit applies
Special Election Period	*First day of the month after the month the MA organization receives an enrollment request, unless otherwise noted.*	Yes – unless capacity limit applies
Medicare Advantage Open Enrollment Period (MA OEP)	First day of the month after the month the MA organization receives an enrollment request	No - the MA organization can choose to be "open" or "closed" for enrollments during this period.

It is possible for an individual to make an enrollment request when s/he is eligible for more than one election period, resulting in more than one possible effective date. Therefore, if an organization receives an enrollment request and determines the applicant is eligible for more than one election

period, the organization must allow the individual to choose the enrollment effective date (see exception in the next paragraph regarding the ICEP). To accomplish this, the organization must attempt to contact the individual, and must document its attempt(s), to determine the individual's preferred effective date. **Note:** This requirement does not apply to beneficiary requests for enrollment into an employer/union sponsored plan using the group enrollment mechanism, as these may be submitted to CMS with the EGHP SEP election type code.

If one of the election periods for which the individual is eligible is the ICEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B.

EXAMPLE

If an individual will be entitled to Medicare Part A and Part B in February his ICEP is November through May. If an MA organization receives an enrollment request from that individual during the AEP, the individual may NOT choose a January 1 effective date and must be given a February 1 effective date for the ICEP because January 1st is earlier than the month of entitlement to Medicare Part A and Part B.

If an individual is eligible for more than one election period but does not indicate a preferred effective date or the organization is unable to contact the individual, the organization must assign an effective date using the following ranking of election periods. The election period with the highest rank generally determines the effective date of enrollment (refer to §30.7 for procedures to determine the effective date of voluntary disenrollment).

Individuals eligible for the SEP EGHP and one or more other election periods who make an election via the employer or union election process will be assigned an effective date according to the SEP EGHP, unless the individual requests a different effective date that is allowed by one of the other elections periods for which s/he is eligible.

Ranking of Election Periods: (1 = Highest, 5 = Lowest)

1. ICEP/IEP-D
2. MA OEP
3. SEP
4. AEP
5. OEPI

30.6.1 - Effective Date of Auto- and Facilitated Enrollments

The effective dates for auto-enrollment and facilitated enrollment are described in §40.1.5 of this chapter.

30.7 - Effective Date of Voluntary Disenrollment

42 CFR 422.68
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not select their effective date of disenrollment. §50.1 includes procedures for handling situations when a beneficiary chooses a disenrollment effective date that is not allowable based on the requirements outlined in this section.

When a member disenrolls through the MA organization or 1-800-MEDICARE, the *dis*enrollment will return the member to Original Medicare. If a member elects a new MA plan while still a member of a different plan, he/she will automatically be disenrolled from the old plan and enrolled in the new plan by CMS systems with no duplication or delay in coverage.

As with enrollments, it is possible for a member to make a disenrollment request when more than one election period applies. Therefore, in order to determine the proper effective date, the MA organization must determine which election period applies to each member before the disenrollment may be transmitted to CMS.

If an MA organization receives a disenrollment request when more than one election period applies, the MA organization must allow the member to choose the effective date of disenrollment. If the member does not make a choice of effective date, then the MA organization must give the effective date that results in the **earliest** disenrollment.

Effective dates for voluntary disenrollment are as follows (refer to §§50.2 and 50.3 for effective dates for involuntary disenrollment).

Election Period	Effective Date of Disenrollment*	Do MA organizations have to accept disenrollment requests in this election period?
Medicare Advantage Open Enrollment Period	First day of the month after the month the MA organization receives the disenrollment request.	Yes
Annual Election Period	January 1 of the following year.	Yes
Special Election Period	Varies, as outlined in §30.4	Yes
Open Enrollment Period for Institutionalized Individuals	First day of the month after the month the MA organization receives the disenrollment request.	Yes

***NOTE:** CMS may allow up to 90 days retroactive payment adjustments for EGHP disenrollments. Refer to §60.6 for more information.

30.8 - Election Periods and Effective Dates for Medicare MSA Plans

42 CFR 422.56, 422.62(*d*)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Individuals may enroll in Medicare MSA plans (should one be offered in their area) only during the ICEP or the AEP; they may not enroll in Medicare MSA plans during a SEP (see exception below). The effective date of coverage is determined by the election period in which an enrollment request is made. Effective dates are provided in §30.6 of this chapter.

Individuals may disenroll from Medicare MSA plans only during the AEP or an SEP. The effective date of disenrollment during an SEP depends on the type of SEP. Additionally, MSA enrollees may not use the MA OEP to disenroll from the MSA.

> **Exception:** To facilitate the offering of employer/union sponsored MSA plans, CMS will permit individuals to request enrollment into an employer/union sponsored MSA plan using the Employer Group Health Plan Special Enrollment Period (EGHP SEP).

30.9 - Closed Plans, Capacity Limits, and Reserved Vacancies

42 CFR 422.60(a)(2), 422.60(b) and 422.66(d)(2)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

An MA organization may specify a capacity limit for one or all of the MA plans it offers and reserve spaces for individual and employer or union group commercial members who are converting from a commercial product to an MA product at the time the member becomes eligible (i.e., conversion enrollments). When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until space becomes available. All requests from MA organizations for a capacity limit should be submitted to the CMS Regional Office account manager.

All MA plans (with the exception of Medicare MSA plans; see §30.8) must accept enrollment requests made during the AEP, ICEP and SEP unless an approved capacity limit applies. Only with an approved number of reserved vacancies may an MA organization set aside openings for the enrollment of conversions (i.e., ICEP enrollment requests).

Unlike the mandatory election periods (AEP, ICEP and SEP), an MA organization has the option to voluntarily close one or more of its MA plans to OEP and OEPI enrollment requests. If an MA plan is closed for OEP and OEPI enrollments, then it is closed to all individuals who are making OEP or OEPI enrollment requests for that plan. All MA plans must accept OEP and OEPI disenrollment requests, regardless of whether or not it is open for enrollment.

> **NOTE**: For purposes of auto-enrollment and facilitated enrollment, MA organizations must ensure that the MA-PD plans into which beneficiaries are deemed to have enrolled have the capacity to accept them. Should a capacity limit be proposed for an MA-PD plan, it must be set high enough to ensure all beneficiaries may be transitioned.

30.9.1 - MA Plan Closures

The decision to be open or closed for OEP and OEPI enrollment requests rests with the MA organization and does not require CMS approval. However, if an MA organization has an MA plan that is open for OEP and OEPI enrollment requests, and decides to change this process, it must notify

CMS and the general public 30 calendar days in advance of the new limitations on the open enrollment process.

If an MA organization has more than one MA plan, those plans may be open or closed to OEP and OEPI enrollment requests independent of one another, as the MA organization determines. Further, each MA plan may be open for OEP and OEPI enrollment requests:

1. Only certain months of the year;

2. Some portion of certain months; and/or

3. During the first 25 days (or any part) of each month.

When an MA plan is voluntarily closed for OEP and OEPI enrollments, it is closed to **ALL** OEP and OEPI enrollment requests, but it must accept enrollment requests made during the ICEP and SEP as well as be open for the AEP, unless an approved capacity limit applies and has been reached (excluding reserved vacancies). CMS may approve a partial service area closure for capacity reasons. If a plan is closed in a portion of its service area for capacity reasons, that plan may be open for OEP and OEPI enrollments in the remaining portion of the service area.

When an MA plan is closed due to an approved capacity limit that has been reached, it may continue to accept ICEP (i.e., conversion) enrollments only if there are reserved vacancies set aside. If there are no reserved vacancies, or once all of these vacancies have been filled, the MA organization cannot accept any new enrollees into the MA plan until space becomes available. Refer to §40.5.1 for more information on enrollment processing after reaching capacity.

Refer to §40.5 of this chapter for additional information on enrollment processing during closed periods.

If an MA organization has an MA plan that is approved by CMS for a capacity limit, it should estimate when a capacity limit will be reached and notify CMS and the general public 30 calendar days in advance of the closing of the open enrollment process. If CMS approves the capacity limit for immediate closing of enrollment, the MA organization must notify the general public within 15 calendar days of CMS approval that it has closed for enrollment.

Exhibit 23 contains three model notices that MA organizations can use to notify the public when they are closing for enrollment. **NOTE:** Public notices must receive CMS approval under the usual marketing review process.

When an MA organization has a plan that re-opens after being closed to OEP and OEPI enrollment requests or as a result of a capacity limit, there is no requirement for the MA organization to notify the general public. However, the MA organization should notify CMS when this occurs.

40 - Enrollment Procedures

42 CFR 422.66

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

An MA organization must accept enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.

An individual (or his/her legal representative) must complete an enrollment request mechanism to enroll in an MA plan and submit the enrollment request to the MA plan during a valid enrollment period. If an individual wishes to elect another MA plan in the same parent organization, he/she must complete a new enrollment request to enroll in the new MA plan. Enrollment may also be made via Auto- and Facilitated enrollment processes as described in §40.1.5 of this chapter and via the group enrollment process for employer or union sponsored plans as described in §40.1.6.

Upon receiving an enrollment request, an MA organization must provide within 10 calendar days, one of the following:

- Acknowledgement notice (as described in section 40.4.1);
- Request for additional information (as described in 40.2.2); or
- Notice of denial (as described in 40.2.3).

If a plan uses the combined acknowledgment/confirmation notice, the plan may send the notice of rejection within 7 calendar days of receiving the *D*TRR indicating a rejection instead of sending the above items (as described in 40.4.2).

Unless otherwise directed in this guidance, the organization must provide required notices in response to information received from CMS on the *D*TRR that contains the earliest notification.

MA organizations may not delay the processing of enrollment requests unless the beneficiary's enrollment request is being placed on a waiting list, as allowed under §40.5.

Refer to §40.2.5 for MA-PD enrollments in which an individual has other qualified prescription drug coverage through an employer or union group.

Special Rule for the Annual Election Period (AEP):

Medicare Advantage (MA) organizations may not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP. Brokers and agents under contract to MA organizations may not accept or solicit submission of paper enrollment forms prior to the start of the AEP. MA organizations and their brokers and agents also should remind beneficiaries that they cannot submit enrollment requests prior to the start of the AEP.

Despite these efforts, CMS recognizes that MA organizations may receive unsolicited paper enrollment forms prior to the start of the AEP, given that marketing activities may begin prior to this date. To be considered unsolicited, the MA organization must have received the paper AEP enrollment request directly from the applicant and not through a sales agent or broker. Other enrollment request mechanisms may not be accepted prior to the actual start of the AEP. Paper AEP enrollment requests received prior to the start of the AEP for which there is indication of sales agent or

broker involvement in the submission of the request (i.e., the name or contact information of a sales agent or broker) must be investigated by the organization for compliance with the requirements in the Medicare Communications and Marketing Guidelines. If an MA organization receives unsolicited paper enrollment forms on or after October 1st but prior to the start of the AEP, it must retain and process them as follows:

- Within 7 calendar days of the receipt of a paper enrollment request, the MA organization must provide the beneficiary with a written notice that acknowledges receipt of the complete enrollment request, and indicates that the enrollment will take effect on January 1 of the following year (refer to Exhibits 4, 4a, 4b and 4c for model notices).

- For AEP enrollment requests received prior to the start of the AEP, the MA organization must submit all transactions to CMS systems (MARx) on the first day of the AEP with an "application date" of the same date. For example, unsolicited AEP paper enrollment requests received October 1 through October 14 must be submitted on October 15th with an "application date" of October 15th of the current year in the appropriate data field on the enrollment transaction. If a beneficiary has submitted more than one AEP paper enrollment request prior to the start of the AEP, the beneficiary will be enrolled in a plan based on the first application that is processed.

- Once the MA organization receives a MARx *D*TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, it must meet the remainder of the requirements (e.g., sending a notice of the acceptance or rejection of the enrollment within 10 calendar days following receipt of the *D*TRR from CMS) provided in §40.4.2.

Note: If organizations receive incomplete unsolicited AEP paper enrollment requests prior to the start of the AEP, they must follow existing guidance for working with beneficiaries to complete the applications (refer to §40.2.2).

Again, this policy applies only to the receipt of unsolicited paper enrollment forms prior to the beginning of the AEP. To help ensure a successful AEP season, it is imperative that organizations follow these steps and submit valid enrollment transactions promptly as directed.

40.1 - Format of Enrollment Requests

42 CFR 422.60(c)
Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

MA organizations must have, at minimum, a paper enrollment form process available for potential enrollees to *request* enrollment in an MA plan.

In addition to the paper enrollment form, MA organizations have the option to accept enrollment requests *through other approved mechanisms* as described in §§ 40.1.2, 40.1.3, 40.1.4 and 40.1.5 below.

40.1.1 - Enrollment Request Mechanisms

Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

The MA organization must use an enrollment mechanism that complies with CMS' guidelines in format and content.

Specific model enrollment forms have been developed for each plan type as follows:

Exhibit 1 - MA coordinated care plans
Exhibit 1b - MSA plans
Exhibit 1c - PFFS plans

Organizations should utilize the model appropriate to the plan type for all enrollment request mechanisms to ensure all required elements are included. CMS has also developed a *model EGHP enrollment (Exhibit 2) for EGHP members, a* model short enrollment *form ("short form")* (Exhibit 3) and a model plan selection *form* (Exhibit 3a) to allow for enrollment requests into another plan (PBP) offered by the same parent organization. *For determining the appropriate use of the short form or model plan selection form, CMS defines parent organization as the contract numbers (H#) and legal entities that are owned and operated by a single organization in a single State.* As a result, a short form or a model plan selection form may be used only for enrollment requests into another plan of the same type (i.e., HMO to HMO, PPO to PPO, or PFFS to PFFS).

Organizations can utilize model enrollment forms included in Exhibits 1-3a, or choose to develop their own materials using these models as a guide. Materials are subject to the CMS review and approval of plan marketing materials.

*In addition to the information collected on the request, the e*nrollment mechanism must include *information indicating that* the applicant acknowledge*s--*

- *T*he requirement to keep Part A and B*;*
- *That they will* abide by the *rules of the* MA plan;
- *The release* of information *to Medicare and other plans. Information may be used to track enrollment and for other purposes, as allowed under federal law*;
- *T*hat enrollment in the MA plan automatically disenrolls him *or* her from any other Medicare health plan and prescription drug plan. Note: The model PFFS and MSA enrollment mechanisms provide language as appropriate; and
- *T*he right to appeal service and payment denials made by the organization.

Please refer to Appendix 2 for a complete listing of required elements that must be included on enrollment mechanisms and Exhibits 1 – 3a for complete information on the*se* statements.

The plan premium is not required *to be displayed or disclosed* on the enrollment mechanism unless it is part of the plan name. Organizations may include the premium *amount* on the enrollment

mechanism if they choose to do so, but they must do so consistently for all PBPs listed on the enrollment mechanism.

Special Needs Plans (SNPs) must include elements on the enrollment mechanism that correspond to the special needs focus of the particular SNP.

Medical Savings Plans (MSA) must include elements on the enrollment form as provided in Exhibit 1b.

No enrollment form or other enrollment request mechanism may include a question regarding binding arbitration, whether the individual receives hospice coverage (except MSA plans) or any other health screening information, with the exception of questions regarding nursing home status (some additional exceptions apply for SNPs; please refer to §40.2, item "D" of this chapter).

Refer to §60.9 for requirements regarding retention of enrollment request mechanisms.

40.1.2 – Electronic Enrollment

42 CFR 422.60(c)
Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

MA organizations may develop and offer electronic enrollment mechanisms made available via an electronic device or secure internet website.

The following *standards*, in addition to all other program requirements, apply to electronic enrollment mechanisms:

- Submit all materials, web pages, and images (e.g. screen shots) related to the electronic enrollment process for CMS approval following the established process for the review and approval of marketing materials and other enrollment request mechanisms.
- Provide individuals with all the information required by *Medicare regulations and communication and* marketing guidelines for the MA program.
- At a minimum, comply with CMS' data security policies.
- Advise each individual at the beginning of the electronic enrollment process that he or she is completing an actual enrollment request to the MA organization.
- Capture the same data as required on the model enrollment form (see Exhibit 1 and Appendix 2).
    - For enrollment requests from one plan to another plan within the same parent organization, the data required on the model short enrollment form are sufficient, provided the plan can verify that the individual is currently enrolled in the parent organization at the time the individual submits the enrollment request.
    - Electronic ICEP enrollment requests from individuals enrolled in a non-Medicare plan under the same organization (or parent organization) and transitioning to the MA plan without a break in coverage may be based on the simplified opt-in enrollment mechanism as described in § 40.1.9.
- As part of any electronic enrollment process, *obtain an electronic signature from the applicant or* include a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool. By taking this affirmative step, the individual indicates his or her intent to enroll. It must also be made clear to the applicant that, by taking this action, he or she agrees to the release *of information* as provided on the model enrollment form (see Exhibit 1), and

attests to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information. *See §40.2 for information about legally binding electronic signatures.*

- The *electronic enrollment* mechanism must capture an accurate time and date stamp at the time the applicant *executes the electronic signature or* activates the step in the previous bullet (i.e. "Enroll Now or I Agree" button or tool). The organization will use this data to establish the application date for the enrollment request. **This time stamp also marks the start of the seven day timeframe for processing the enrollment request, as it is at this time that the enrollment request is considered by CMS to be received by the MA organization.**
- If a legal representative is completing this enrollment request, he or she must attest that he or she has such authority to make the enrollment request and that proof of this authority is available upon request by the MA organization or CMS.
- Inform the individual of the effects of completing the electronic enrollment, including that the individual will be enrolled (if approved by CMS), and that he or she will receive notice (of acceptance or denial) following submission of the enrollment to CMS.
- Include a tracking mechanism (e.g., a confirmation number) to provide the individual with evidence that the MA organization has received the electronic enrollment request.
- Optionally, may request or collect premium payment or other payment information, such as a bank account number or credit card numbers.
- Maintain electronic records that are securely stored and readily reproducible for the period required in §60.9 of this chapter. The MA organization's record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.
- Plans have the option of obtaining technical and related services from outside entities in support of the MA organization's electronic enrollment mechanism, (e.g. licensed software). MA organizations may use downstream entities, such as a broker or third party website, as a means of facilitating and capturing the electronic enrollment request. However, organizations retain complete responsibility for ensuring enrollment policies in this guidance are followed, and for ensuring the appropriate handling of any sensitive beneficiary information provided as part of the online enrollment, including those facilitated by downstream entities.
- From the point at which an individual selects the plan of his or her choice on the third-party website and begins the online enrollment process, CMS holds the organization responsible for the security and privacy of the information provided by the applicant and for the timely disclosure of any breaches.

Medicare Online Enrollment Center

In addition to the process described above, CMS offers an online enrollment center (OEC) through the Medicare.gov website and the 1-800-MEDICARE Call Center for enrollment into Medicare Advantage plans (except for MSA) and Medicare prescription drug plans. The date and time "stamped" by the Medicare OEC will serve as the application date for purposes of determining the election period and enrollment effective date. MA organizations must promptly retrieve enrollment requests from the OEC and should check for requests at least daily.

40.1.3 - Enrollment via Telephone

(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

MA organizations may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call to a plan representative or agent. MAOs may also accept enrollment requests during

communications initiated by the organization when, during the course of outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's MA plans.

The following *standards apply*, in addition to all other applicable program requirements:

- Enrollment requests from individuals with whom the organization does not have an existing business relationship may be accepted only during an incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.
- For all telephonic enrollment requests, the MA organization must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his or her authorized representative.
- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 2), and a verbal attestation of the intent to enroll. If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in section §60.9.
- Include a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g. a confirmation number).
- Optionally, organizations may request or collect premium payment or other payment information needed, such as a bank account number or credit card numbers, to process the form of premium payment requested by the individual.
- A notice of acknowledgement and other required information must be provided to the individual as described in §40.4.1.
- Telephonic enrollment requests into a plan offered by the same parent organization may be based on the model short enrollment form (Exhibit 3) or the model plan selection form (Exhibit 3a) instead of the comprehensive individual enrollment form.
- Telephonic ICEP enrollment requests from individuals enrolled in a non-Medicare plan under the same organization (or parent organization) and transitioning from the non-Medicare plan to the MA plan without a break in coverage may be based on the simplified opt-in enrollment mechanism as described in § 40.1.9.

The MA organization must ensure that all MA eligibility and enrollment requirements provided in this chapter are met. Scripts for completing an enrollment request in this manner must be developed by the MA organization *and submitted to CMS for review and approval*. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2, and must receive CMS approval in accordance with *applicable Medicare regulations* before use.

40.1.4 - Default Enrollment Option for Medicaid Managed Care Plan Enrollees who are Newly Eligible for Medicare Advantage

42 CFR 422.66(c) and 422.68(a)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Subject to prior CMS approval, MA organizations may automatically enroll newly eligible Medicare beneficiaries into a dual eligible MA special needs plan (D-SNP). Default enrollment is permitted only for individuals who:

- are newly eligible for Medicare Advantage;
- are currently enrolled in a Medicaid managed care plan offered by the MA organization (or by an entity under the same parent organization as the MA organization); and
- will remain in the Medicaid managed care plan upon their conversion to Medicare.

CMS approval of default enrollment

To qualify for default enrollment, an MA organization must have an affiliated Medicaid managed care plan. An affiliated Medicaid managed care plan is one that is offered by the MA organization that also offers the D-SNP (or is offered by an entity under the same parent organization as the MA organization). The MA organization must be able to demonstrate:

- State approval for the use of a default enrollment process in its contract with the state Medicaid agency; and
- State agreement to provide the information that is necessary for the MA organization to identify individuals in their Medicaid managed care plan who are in their MA initial coverage election period.

NOTE: Data provided by the State must include all information necessary to submit the enrollment transaction to CMS (i.e., Medicare number, date of birth, etc.).

MA organizations must have a minimum overall quality rating from the most recently issued ratings of at least 3 stars (or be a low enrollment contract or new MA plan as defined in § 422.252) and must not have any prohibition on new enrollment imposed by CMS. MA organizations must submit proposals to their CMS Account Manager via HPMS and receive CMS approval before beginning any default enrollments under this authority.

Proposals for default enrollment must include a description of the MA organization's process to identify individuals eligible for default enrollment, including:

- Those currently enrolled in a Medicaid managed care plan offered by the organization and who are about to convert to Medicare;
- How the process ensures the organization will identify eligible individuals in time to provide the required written notice to these individuals no fewer than 60 days prior to the date of their initial Medicare eligibility (the conversion date); and
- How the process ensures identification of individuals whose upcoming Medicare eligibility is based on disability as well as age.

Notice to individuals about automatic (default) enrollment

Proposals must include a copy of the required written notice and copies of any written, telephonic or electronic outreach materials for CMS prior approval, as well as a description of the organization's outreach activity for its default enrollment process. The required written notice must include the following:

- Information and materials required under § 422.111 for initial enrollments (e.g., Evidence of Coverage and Summary of Benefits);
- Information on how to opt-out of (decline) the enrollment prior to the enrollment effective date, and either enroll in Original Medicare or choose another MA plan. This must include the opportunity to contact the MA organization either in writing or by telephone to a toll-free number. The MA organization is prohibited from discouraging declination. The organization will submit opt-out requests to CMS as enrollment cancellations;
- Information on the differences in premium, benefits, and cost sharing between the individual's current Medicaid managed care plan and the D-SNP;
- Information on the process for accessing care under the D-SNP; and
- A general description of alternative Medicare health and drug coverage options available to an individual in his or her Initial Coverage Election Period.

Default enrollment process

The MA organization will send the enrollment transaction to CMS at the same time that it sends the written notice (i.e., no fewer than 60 days prior to the conversion date). Default enrollment transactions must be submitted with election code type 'J' and must always use the first day of an individual's ICEP as the application date. The enrollment effective date must always be the date of the individual's first entitlement to both Medicare Part A and Part B. Opt-out requests received after coverage begins are to be processed as disenrollment requests; once enrolled in the MA plan, these individuals may use the MA OEP to either enroll in Original Medicare or choose another MA plan (see § 30.4 for more information).

Approval Period

CMS may approve an MAO using the default enrollment for a period of up to five years. Such approval shall continue after contract consolidations or other CMS-approved changes to the Plan Benefit Package if the D-SNP continues to be offered by the same parent organization and continues to meet all qualifying criteria for default enrollment. CMS may suspend or rescind approval prior to the expiration of this period if CMS determines the MA organization is not in compliance with the requirements of this section. An MA organization that wants to continue default enrollment after the expiration of an approval period must re-apply and CMS must approve the request to use default enrollment before the MA organization begins default enrollments again. MA organizations may not continue to use default enrollment if they are pending a response from CMS at the time their approval period expires.

40.1.5 - Auto- and Facilitated Enrollment

42 CFR 423.34
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

CMS requires that MA organizations offering both MA-PD and MA-only plans have a process for auto- and facilitated enrollment. All LIS eligible individuals who elect an MA plan without Medicare prescription drug benefits ("MA-only plan") will be auto- or facilitated enrolled into an MA-PD plan in the same organization or into a PDP offered by the same organization, unless the individual declines the enrollment. The MA organization's auto- and facilitated enrollment processes will occur monthly. As noted in the preamble to the final regulation for Part D (Federal Register/Vol. 70, No. 18, January 28, 2005), the legal authority for both auto- and facilitated enrollment processes is technically termed "facilitated" enrollment, since auto-enrollment is limited to PDPs. However, the term "auto-

enrollment" is used here to denote the process that applies to full-benefit dual eligible individuals, and "facilitated enrollment" to others with LIS.

CMS has safeguards in place to prevent existing MA and cost plan enrollees from being auto- or facilitated enrolled by CMS into a PDP. However, there may be instances in which a beneficiary's request to enroll into an MA plan will not yet be reflected in CMS systems at the point in time when CMS processes auto- or facilitated PDP enrollments. In these cases, the beneficiary will receive a notice from CMS informing him/her that s/he has been enrolled into a PDP. However, once the beneficiary's request to enroll into the MA plan is processed by CMS, it will prevail over the previously processed auto- or facilitated PDP enrollment submitted by CMS.

Please note this section does not apply to MA organizations that offer only MA-PD plans, as all their enrollees already have Part D coverage. Nor does it apply to PFFS plans offered by organizations that do not offer any MA-PD plans (these beneficiaries are included in the standard CMS auto/facilitated enrollment process into PDPs), nor to MA organizations in the U.S. territories, including Puerto Rico, or to employer sponsored MA plans.

Starting January 1, 2010, CMS implemented the Limited Income Newly Eligible Transition (Limited Income NET) demonstration, which modified its procedures for auto/facilitating enrollment of LIS beneficiaries into PDPs for those who have retroactive enrollment effective dates. That demonstration does not impact the auto/facilitated requirements for MA organizations as specified in this section, except for MA-PFFS plans that autoenroll new full benefit dual eligible enrollees into a PDP owned by the same organization (see §40.1.5, item B as well as Exhibit 27A).

A. Populations

1. Auto-Enrollment

Full-benefit dual eligibles in MA-only plans will be auto-enrolled by the MA organization into an MA-PD plan. Full-benefit dual eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare cost-sharing (sometimes known as QMB-plus or SLMB-plus). Please note that full-benefit dual eligible individuals do not include those eligible *only* for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI). In Part D, these distinctions are key to distinguishing full-benefit dual eligibles, who need to be auto-enrolled, from other types of dual eligibles, who need to be facilitated enrolled.

Full-benefit dual eligible individuals to be auto-enrolled include those who are full-benefit dual eligible upon initial enrollment into an MA-only plan, as well as existing Medicare enrollees of an MA-only plan who become newly Medicaid eligible. This includes full-benefit dual eligible MA-only enrollees who reside in the 50 states or the District of Columbia.

This excludes full-benefit dual eligibles who:

- Live in any of the five U.S. territories;
- Live in another country;

- Are individuals for whom an employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored MA-only plan, including MA-only "800 series" plans.
- Are incarcerated, as defined in §10;
- Are not lawfully present in the U.S.; or
- Have opted out of auto-enrollment into the Part D benefit.
- [For MA-PFFS only] Are already enrolled in a stand-alone Prescription Drug Plan

2. Facilitated enrollment

Other LIS eligibles are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e. only eligible for Medicaid payment of Medicare premiums and/or cost-sharing); SSI-only (Medicare and Supplemental Security Income [SSI], but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for either the full or partial level of the LIS.

Other LIS eligible individuals to be facilitated enrolled include those who are Other LIS eligible upon initial enrollment into an MA-only plan, as well as existing Medicare enrollees of an MA-only plan who become newly Other LIS eligible. This includes Other LIS eligible MA-only enrollees who reside in the 50 states or the District of Columbia.

This excludes Other LIS eligible individuals who:

- Live in any of the five U.S. territories,
- Live in another country,
- Are individuals for whom the employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored MA-only plan, including MA-only "800 series" plans,
- Are incarcerated, as defined in §10;
- Are not lawfully present in the U.S.; or
- Have opted out of facilitated enrollment into the Part D benefit.
- [For MA-PFFS only] Are already enrolled in a stand-alone Prescription Drug Plan

B. Auto/Facilitated Enrollment Process

The procedure for auto/facilitated enrollment is as follows:

1. The MA organization will identify full-benefit dual eligibles to be auto-enrolled, and Other LIS eligibles to be facilitated enrolled. Please see subsection C for details on how to distinguish the two populations.

    a. Auto/facilitated enrollment specifically excludes individuals in employer-sponsored MA-only plans, including "800 series" plans, and individuals with Retiree Drug Subsidy (RDS).

    b. For PFFS plans, the organization must exclude individuals who are already enrolled in a stand-alone PDP. The organization may submit a Batch Eligibility Query (BEQ) transaction or access the MARx online query (M232 screen) to determine whether individuals are enrolled in a stand-alone PDP.

2. The MA organization will then identify MA-PD plans in the same service area, and in the same MA organization, with the lowest combined Part C and Part D premium amount. If more than one MA-PD plan have the same lowest premium amount, auto-enrollment must be random among the available MA-PD plans. The selection of MA-PD plan is without regard to the Part C cost-sharing. The only exception to this is when the MA-PD plan is a high-deductible plan, unless the high-deductible plan is the only MA-PD plan offered in the area. Please note that the Part D premium is the dollar amount equaling the premium charged to a beneficiary with a 100 percent premium subsidy.

   If an MA Special Needs Plan (SNP) meets these criteria, the MA organization must ensure that the individual meets the eligibility criteria for the SNP (e.g. type of dual eligible, type of chronic condition, or institutionalized). Please note the "MA full dual file" uses LIS deemed reason code to identify full duals, meaning they were full dual in at least one month in the past year; it cannot be used by MA organizations to confirm dual status in the current month. If the MA SNP does not meet the criteria of lowest combined Part C and D premium (with the Part D premium equaling the premium charged to a beneficiary with a 100 percent premium subsidy), the MA organization may not auto-enroll full benefit dual eligibles into it, even if it is a dual eligible SNP.

   Organizations offering both an MA-PD PFFS plan and a stand-alone PDP in the same region with a basic benefit and a premium at or below the low-income premium subsidy amount for that region may auto/facilitate enrollment into either the MA-PD PFFS plan or the PDP, but must apply this policy consistently for all PFFS plans offered by the organization. CMS will conduct auto/facilitated enrollment of LIS individuals enrolled in MA-only PFFS plans where the organization does not offer an MA-PD PFFS plan, even if they also offer a stand-alone PDP.

3. Within 10 calendar days of identifying an individual as needing auto/facilitated enrollment, the MA organization sends an auto/facilitated enrollment notice to the beneficiary (see Exhibits 27, 27A, 28 and 28a).

4. If the person does not respond or opt-out by the deadline below, submit a Code 61 transaction (PBP change) for the auto/facilitated enrollment into the MA-PD plan and include the appropriate effective date within the timelines specified below (see subsection C). The new MA-PD plan will be notified of the auto/facilitated enrollment via a transaction reply.

   - Auto-enrollment – within 10 calendar days of sending notice
   - Facilitated enrollment – by last day before effective date of facilitated enrollment

C. Effective Date of Auto/Facilitated Enrollments

1. Auto-Enrollment

The effective date of auto-enrollment is retroactive to the first day of the month the individual first became a full-benefit dual eligible, or January 1, 2006, whichever is later. For individuals who are full-benefit dual eligible upon enrollment into an MA-only plan, the effective date would be retroactive to the effective date of enrollment in the MA-only plan. For existing MA-only Medicare enrollees who subsequently become Medicaid eligible, the effective date is retroactive to the first day of the month the person became Medicaid eligible. In no case will the effective date of auto-enrollment precede the date that the individual became an enrollee of the MA organization.

For MA-PFFS plans that elect to auto-enroll a full-benefit dual eligible beneficiary into a PDP offered by the same organization, the effective date will be prospective, i.e., the first day of the second month after the enrollee is identified as a new full benefit dual eligible. This is because CMS implemented the Limited Income NET demonstration in January, 2010, in which a single contractor addresses all retroactive periods of PDP auto-enrollment. The MA-PFFS may not submit an election on behalf of a beneficiary into the Limited Income NET demonstration contractor. To ensure the beneficiary is aware s/he can request retroactive coverage from the demonstration contractor, Exhibit 27a includes instructions on how to do so.

There is nothing that prohibits a full-benefit dual eligible from initially electing an MA-only plan. To ensure they understand the consequences of doing so, marketing material and the acknowledgement letter emphasize that prescription drugs are not covered.

2. Facilitated Enrollment

The effective date of facilitated enrollment for all Other LIS eligible members is the first day of the second month after the person is identified as qualifying for facilitated enrollment. For example, if the plan is notified in August 2010 that an existing member of an MA-only plan has become LIS eligible, the effective date is October 1, 2010.

The MA organization may move up the effective date of a facilitated enrollment by a month if an Other LIS beneficiary requests this in a timely fashion, i.e. before start of earlier month. The SEP under §30.4.4 #12 should be used.

> **Example:** The MA organization facilitates enrollment of an Other LIS eligible in May, 2010, effective July 1, 2010. The beneficiary receives the facilitated enrollment by the last day in May, and requests the MA organization makes the facilitated enrollment effective June 1. The MA organization submits an enrollment transaction to do so.

3. Distinguishing Between Full-Benefit Dual Eligible and Other LIS Individuals

MA organizations need to distinguish full benefit dual eligibles from others with LIS for purposes of setting the effective date. The first step is to identify all LIS eligibles in the MA-only plan. In the past, CMS did not transmit a data element to plans that could be used to distinguish full-benefit dual eligibles from other LIS. As a result, CMS sends a monthly "Auto Assignment Full Dual Notification File" (for file format and technical specifications, please see section 8.1 of the Plan Communications

User Guide, on the CMS website at http://www.cms.hhs.gov/mmahelp/. This file identifies full-benefit dual eligibles.

However, starting December, 2010, the monthly membership report (MMR) will include a new field (Medicaid dual status code) that will provide the dual status code of the enrollee, if that enrollee has Medicaid status. The new field will be aligned with the already-existing Field 40 (Current Medicaid Status). If Field 40 indicates that the enrollee has Medicaid status, Field 85 will provide the dual status code for that enrollee. Field 40 indicates that an enrollee is Medicaid when that enrollee has a Medicaid period reported to CMS for either the month prior to payment or two months prior to payment. Please note that Field 40 and, thus the new field, are not related to payment, but are provided for purposes of benefits coordination and bidding. The new field will be coded as follows:

The valid values when Field 40 = 1 are:

01 = Eligible is entitled to Medicare- QMB only
02 = Eligible is entitled to Medicare- QMB AND Medicaid coverage
03 = Eligible is entitled to Medicare- SLMB only
04 = Eligible is entitled to Medicare- SLMB AND Medicaid coverage
05 = Eligible is entitled to Medicare- QDWI
06 = Eligible is entitled to Medicare- Qualifying individuals
08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QDWI or QI) with Medicaid coverage
09 = Eligible is entitled to Medicare- Other Dual Eligibles but without Medicaid coverage
99=Unknown

The valid value when Field 40 = 0 is:

00 = No Medicaid Status

The valid value when Field 40 is blank is: Blank

Full-benefit dual eligible beneficiaries are represented by dual status codes 02, 04, and 08.

To ensure a sufficient period of transition, CMS will continue to send the Auto Assignment Full Dual Notification File to identify the subset of the LIS enrollees in the MA-only plan who are full-benefit dual eligibles. Plans may begin using the MMR instead, but starting August, 2011, plans will be required to use the MMR as CMS will discontinue transmission of the Auto Assignment Full Dual Notification File.

To determine the auto-enrollment effective date, identify the LIS copay start date data provided on other files (i.e., Transaction Reply Report or monthly LIS history report). MA-PFFS plans that elect to auto/facilitate enroll new LIS beneficiaries into a PDP offered by the same organization do not need to distinguish between full-benefit dual eligible enrollees and others with LIS because the effective date will always be prospective.

The remaining LIS eligibles in the MA-only plan qualify for facilitated enrollment, and the effective date should be set as noted in item 2 above.

D. Notice

The MA organization will notify the beneficiary in writing that she/he will be enrolled in the given MA-PD plan on the specified effective date. The notice must be sent within 10 calendar days of identifying the individual as qualifying for auto/facilitated enrollment. The notice will inform the beneficiary that they may choose another Part D plan (either another MA-PD plan or Original Medicare with a PDP) or opt out of auto/facilitated enrollment into the Part D benefit. If the beneficiary does not opt out, or choose another Part D plan within the specified deadline, the person's silence will be deemed to be an election of the auto/facilitated enrollment and it will take effect on the effective date. These individuals will also be informed they have a Special Enrollment Period (SEP) that permits them to change Part D plans, even after the auto/facilitated enrollment takes effect.

1. Auto-Enrollment

Please use the model notice language in Exhibit 27. For MA-PFFS auto-enrolling into a PDP, please use Exhibit 27a. The deadline for responding is 10 calendar days from when the notice is sent.

2. Facilitated enrollment

Please use the model notice language in Exhibit 28. For MA-PFFS auto-enrolling into a PDP, please use Exhibit 28a. The deadline for responding is the last day before the facilitated enrollment effective date.

E. Opt-Out

Full-benefit dual eligible and Other LIS individuals may opt-out, or affirmatively decline, the Part D benefit. Beneficiaries may opt-out verbally or in writing. For an MA-only plan enrollee, this primarily means declining auto/facilitated enrollment into an MA-PD plan in the same organization and maintaining enrollment in the MA-only plan. MA organization may check the common User Interface to see if the individual has previously opted out; if so, the person should not be auto/facilitated enrolled. Once a beneficiary has opted out, the MA organization should document this and not include him/her in future auto/facilitated enrollment processing.

The MA plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (see Exhibit 29) within 10 calendar days of the individual's request to opt-out. If a beneficiary opts out of auto/facilitated enrollment by the deadline in the auto/facilitated notice, do not submit an enrollment transaction that would move them to an MA-PD plan. This will have the effect of leaving him/her in the MA-only plan.

If the individual opts-out after the Code 61 transaction has been submitted, the effective date of returning to the MA-only plan is normally prospective, i.e. first day of the following month. However, through the 15th of the month after the month in which the notice was sent, at a full-dual eligible beneficiary's request, the MA organization may restore the person to the MA-only plan retroactive to the auto-enrollment effective date. This is accomplished by submitting a Code 61 transaction with the same effective date, and setting the opt-out flag as noted below.

Individuals who want to opt-out of auto/facilitated enrollment into an MA-PD plan must do so with their MA organization, not through 1-800-MEDICARE. This differs from the procedure for individuals who want to opt-out of auto/facilitated enrollment into a stand-alone PDP. If a 61

transaction has already been submitted to move the person to the MA-PD plan, the MA organization sends another 61 transaction (to move the person back to the MA-only plan), setting the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment) . If it has not, submit just the opt out indicator on a 79 transaction.

An individual who opts out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto/facilitated enrollment processes. To obtain Part D benefits, the beneficiary simply makes a voluntary request to enroll into a plan that offers Part D benefits.

F. Special Procedures for Individuals With Employer Coverage

When the individual's employer or union-sponsored enrollment, including in "800 series" plans, or Retirement Drug Subsidy (RDS) status is known, the MA organization shall exclude the individual from auto/facilitated enrollment. It is possible the MA organization will not be aware an individual has RDS until they submit a Code 61 transaction to auto/facilitate his/her enrollment. As with all enrollment transactions for individuals with RDS, MARx will enforce a two-step process, initially rejecting the transaction. The MA organization must follow normal procedures of confirming with the beneficiary that she/he wants to be enrolled in the Part D benefit and, if confirmed, resubmit the transaction with the employer subsidy override.

G. Information Provided to Auto/Facilitated Enrolled Beneficiaries

The MA-PD plan into which the beneficiary has been auto/facilitated enrolled must send a modified version of the pre- and post-enrollment materials required to be provided to new enrollees. If the effective date is retroactive into the previous calendar year, only send the current year's version of the documents below.

Prior to effective date, the MA-PD plan must send:

- The information required in §40.4.1, and

- A Summary of Benefits (those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto/facilitated enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment request, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

After the effective date of coverage:

- The guidance in §40.4.2 applies, including guidance on what to do if the MA-PD plan is not notified early enough of an auto/facilitated enrollment to meet the timelines in §40.4.1 on materials required to be provided prior to the effective date.

H. Summary of Differences between Auto- and Facilitated Enrollment Processes

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Steps	• Identify full dual eligibles in MA-only plan who need to be enrolled into MA-PD plan • Send notice to beneficiary within 10 calendar days of identifying need for person to be auto-enrolled • If no answer or person does not opt out within 10 calendar days, submit 61 transaction to move to MA-DPD plan	• Identify non-full dual LIS beneficiaries in MA-only plan who need to be enrolled into MA-PD plan • Send notice to beneficiary within 10 calendar days of identifying need for person to be facilitated enrolled • If no answer or person does not opt out by last day before effective date of facilitated enrollment, submit 61 transaction to move to MA-PD plan
Who needs to be moved	• Full dual who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became Medicaid eligible and is thus newly full dual	• Non-full dual with LIS who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became LIS-eligible
Who does not need to be moved	• Those who have already opted out • Those with RDS • Those in "800 series" employer sponsored plans • Those in employer sponsored plans (other than "800 series" plans)	• Those who have already opted out • Those with RDS • Those in "800 series" employer sponsored group plans • Those in employer sponsored plans (other than "800 series" plans)
Data to identify those in MA-only plan who need to be moved to MA-PD plan	Monthly MA full dual file or on MMR with dual status code 02, 04, or 08	LIS data (*D*TRR or monthly LIS history report): • Premium subsidy = 25%, 50%, 75% OR • Premium subsidy = 100 *and* LIS copay = 4 (15%) OR • Premium subsidy = 100 *and* LIS copay = 1, 2, or 3, *and* person is not on MA full dual file or on MMR with dual status code 02, 04, or 08

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Plan Into Which Beneficiary Should be Enrolled	MA-PD plan with the lowest combined Part C and D premium	MA-PD plan with the lowest combined Part C and D premium
Notice to send	Exhibit 27 (27a if applicable)	Exhibit 28 (28a if applicable)
Effective date	• First day of month person qualified for LIS (will be retroactive) • Cannot be prior to start of enrollment in the MA-only plan	• First day of second month after person identified as needing enrollment • Cannot be prior to start of enrollment in the MA-only plan
Opt out	• Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 29) • If submitting 61 transaction to move beneficiary back to MA-only, set Opt-Out flag to Y (field 38)	• Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 29) • If submitting 61 transaction to move beneficiary back to MA-only, set Opt-Out flag to Y (field 38)

Data on Transaction	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Application date	First day of month prior to enrollment effective date OR day after current application date on MA-only plan enrollment, whichever is later.	First day of month prior to effective date of the enrollment
Election type Code	Z = MA auto-enrollment period*	U = Dual/LIS Special Enrollment Period
Enrollment Source Code	E (MA-submitted auto-enrollment)*	F (MA-submitted facilitated enrollment)

* Use of the enrollment period of "Z" and enrollment source code of "E" permits these 61 transactions for retroactive auto-enrollments to bypass normal MARx suspension of processing for retroactive effective dates (i.e. they will process immediately).

40.1.6 – Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage

MA organizations may choose to accept voluntary enrollment requests directly from the employer or unions who sponsor MA coverage for its members in any of the enrollment mechanisms described in this guidance (except auto or facilitated enrollment). In addition, the MA organization may also accept enrollment requests using either the optional enrollment request mechanism or group enrollment process described in this section.

It is the MA organization's responsibility to ensure that all applicable MA enrollment requirements are met, regardless of the process utilized, as required by CMS. In any case, the enrollment requests

provided to the MA organization by the employer or union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan.

For enrollments processed using the SEP EGHP, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of enrollment into the employer or union group-sponsored plan. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the organization receives the request.

40.1.6.1 - Group Enrollment Mechanism

CMS will allow an MA organization to accept enrollment requests into an employer or union sponsored MA plan using a group enrollment process in which beneficiaries enroll in an employer or union sponsored MA plan. Beneficiaries participate in this process through advance notification that provides each individual with all the information necessary to make an informed choice. Furthermore, the process must provide CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. It is the MA organization's responsibility to ensure the group enrollment process meets all applicable MA enrollment requirements. MA organizations must ensure that any contracts and other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.

The group enrollment process must include providing the following information to each beneficiary as follows:

- Beneficiaries participate in the group enrollment mechanism by receiving an advance notice that the employer/union intends to enroll them for a prospective coverage effective date in an MA plan that the employer/union is sponsoring; and

- Clear instruction that the beneficiary may affirmatively opt out of such enrollment; explaining the process to opt-out; and any consequences to employer or union benefits opting out would bring; and

- This notice must be provided by the MA organization, or the employer or union acting on its behalf, not less than 21 calendar days prior to the effective date of the beneficiary's enrollment in the employer/union sponsored MA plan; and

- Additionally, the information provided to each beneficiary must include a Summary of Benefits offered under the employer/union sponsored MA plan, as well as an explanation of how to get more information about the MA plan, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available to the beneficiary; and

- Each individual must also receive in the group enrollment notice materials the information contained in Exhibit 2 under the heading "Please Read & Sign Below."

The organization must ensure all of the above requirements are met prior to submission of the enrollment transactions to CMS. For enrollments processed using the SEP EGHP, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems.

The employer or union must provide in the group enrollment file(s) all the information required for the MA organization to submit a complete enrollment request transaction to CMS, including permanent residence information (refer to Appendix 2 of this chapter for a complete list of the required data elements and any other relevant CMS systems guidance). Records must be maintained as outlined in §60.9 of this chapter.

40.1.6.2 - Optional Mechanism For MA Group-sponsored plan Enrollment

This enrollment request mechanism is optional for MA organizations and may not be required. Therefore, MA organizations may specify the employers or unions, if any, from which they will accept this enrollment request format. It is the MA organization's responsibility to ensure that the process it uses, as well as the process used by the employer or union, meets the following requirements:

The MA organization must inform its Regional Office Account Manager of its intent to use this mechanism and identify the employer group(s) or union(s) for which it will be accepting enrollments made in this manner.

The enrollment information (i.e., the electronic file) submitted to the MA organization by an employer or union (or TPA) must accurately reflect the employer's or union's record of the election of coverage made by each individual according to the processes the employer or union has in place, and may be accepted without a paper MA enrollment request form.

Sales package minimum information requirements are not changed by using this option. These include, but are not limited to, providing the applicable rules of the MA organization. Each individual's enrollment request must clearly denote his/her agreement to abide by the MA organization rules, certify his/her receipt of required disclosure information and include authorization by the beneficiary for the disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (and its designees) and the MA organization. The requirements for all other information provided to enrollees, both pre- and post-enrollment, are unchanged by this option and must be satisfied.

The enrollment request transaction must include all the data necessary for the MA organization to determine each individual's eligibility to make an enrollment request as described in §20 of this chapter of the MMCM. Agreements with employer groups or unions should identify required data elements. A detailed list of these elements is provided *in* Appendix 2.

This alternate enrollment request mechanism is used in place of paper MA enrollment request forms and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the application date of enrollments processed using the SEP EGHP will be the first day of the month prior to the effective date of enrollment into the employer/union sponsored plan. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the enrollment submitted by the employer or union.

Effective date calculation of voluntary enrollment requests and the collection and submission of enrollment requests to CMS will follow existing procedures.

To accept electronic records of employer or union enrollment requests, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS web site at: http://www.cms.hhs.gov/informationsecurity for additional information.)

The employer's or union's record of the request to enroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS, as necessary, and be maintained (by the employer/union or the MA organization, as they agree) following the guidelines for MA enrollment request forms (see §60.9). Included in this requirement is the MA organization's record of information received from the employer or union.

40.1.7 - Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow MA organizations to accept enrollment requests in an agreed-upon electronic file format from qualified SPAPs, provided the SPAP has met the following requirements:

- The SPAP must attest, as required by §40.2.1 of this guidance, that it has the authority under state law to enroll on behalf of its members.
- The SPAP must coordinate with the MA Organization to provide the required data elements for the organization to process and submit an enrollment request to CMS.
- The SPAP must provide a notice to its members in advance of submitting the requests that explains that it is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, MA organizations that agree to accept mass enrollment requests from SPAPs are required to process them like any other enrollment and in accordance with notification timeframes. Additionally, the organization must ensure the SPAP has met the above requirements prior to submission of the enrollment transaction to CMS. It is important for the MA organization to work with the SPAP in the event that the organization encounters any problems processing the enrollment request in the format provided. Because the SPAP is the authorized representative of the beneficiary, the organization is responsible for following up with the SPAP if the enrollment is incomplete in any way (to obtain missing information) or if the enrollment is conditionally rejected due to the existence of employer or union sponsored drug coverage (to confirm that the individual understands the implications of enrolling in a Part D plan).

Special note for SPAP enrollment requests during the AEP - For enrollment processing purposes, the application date on the enrollment transaction submitted to CMS for the AEP must be set to October 15th. This will ensure that subsequent beneficiary-generated enrollment requests made during the AEP will supersede the SPAP enrollment in CMS systems.

40.1.8 – Re-Assignment of Certain LIS Beneficiaries

CMS has the discretion to re-assign LIS beneficiaries, including situations in which their current MA plan will terminate. CMS will announce its intent to conduct reassignment in the Call Letter. CMS will

conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified. Affected MA organizations are not responsible for initiating any disenrollment transactions for reassigned beneficiaries. Gaining PDP sponsors are only responsible for responding to the CMS enrollment transaction promptly when they receive it and for providing appropriate beneficiary notices and materials, as described below.

A. Population to be Re-Assigned

CMS will reassign all current LIS enrollees in terminating MA plans. This includes non-renewing MA only plans, as well as MA-PD plans and MA PFFS plans. CMS will perform this reassignment when plan benefit packages are being non-renewed in their entirety, as well as MA plans that will continue but have service area reductions (SARs). In the case of an MA-only or MA-PD plan with a SAR, reassignment will only be performed for counties that will no longer be served by the plan in the following year).

Beneficiaries who have LIS this year and will continue to do so next year will be included in this reassignment process, regardless of whether the individual was assigned to or voluntarily enrolled in a plan. The only exception is when an LIS beneficiary in an MA-PFFS plan that does not offer drugs is concomitantly enrolled in a stand-alone PDP. In these cases the beneficiary will not be reassigned.

Reassignment is not performed for LIS beneficiaries in a non-renewing MA-only or MA-PD plan in the U.S. Territories, or in an employer-sponsored MA-only or MA-PD plan.

The actual reassignment process is typically run on a single day in mid-October. CMS will only reassign beneficiaries who meet the above criteria as of the day of the reassignment run. CMS does not subsequently "sweep" for individuals who may meet the criteria at later points in time.

B. Re-assignment Process

CMS will reassign LIS beneficiaries from a non-renewing MA plan or MA plan with a SAR to a stand-alone prescription drug plan (PDP). Beneficiaries retain the option to elect another MA plan.

CMS will attempt to reassign beneficiaries to a PDP offered by the same organization that offers the MA plan in which they are currently enrolled, wherever possible. CMS will identify PDPs that qualify to receive reassignment and are sponsored by the same parent organization (see §40.1.5 in Chapter 3 of the Medicare Prescription Drug Benefit Manual for details on PDPs to which beneficiaries will be reassigned as well as for the responsibilities of those "gaining" PDPs). If the organization has more than one such plan in that region, CMS will randomly reassign beneficiaries among those plans.

If the organization does NOT offer a qualifying PDP, CMS will randomly reassign affected beneficiaries to PDP sponsors that have at least one qualifying PDP in that region. CMS will follow the two-step process used under auto/facilitated enrollment (i.e. random distribution first at the sponsor level, then randomly among qualifying plans within the sponsor).

C. CMS Notification to Beneficiaries

CMS will ensure that all beneficiaries being re-assigned are notified. These notices will be on blue paper, and will instruct beneficiaries who are being reassigned because of a premium increase to

contact their current plan if they wish to remain with the plan for the following year. Per section 1860 D–14 (c) of the Social Security Act, CMS will also provide reassigned beneficiaries with information on formulary differences between the individual's former plan and new plan (with respect to the individual's drug regimen), and a description of the right to coverage determination, exception, reconsideration, appeal or grievance.

D. Plan Communication to Affected Beneficiaries

Non-renewing MA plans or MA plans with a SAR are not required to send any beneficiary notices specific to the reassignment process. Please refer to the Call Letter for details on general notification requirements related to non-renewals and SARs.

"Gaining" PDPs are responsible for providing enrollment confirmation (See Exhibit 29 of Chapter 3 of the Prescription Drug Manual) and enrollment materials to beneficiaries within 10 calendar days of receiving confirmation of reassignment on a *D*TRR.

40.1.9 – Simplified (Opt-In) Enrollment Mechanism

42 CFR 422.66(d)(5)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

This mechanism permits an MA organization to use data it has from its non-Medicare lines of business (commercial, Marketplace, Medicaid, etc.) to obtain some of the information it would normally need to receive from the beneficiary in the enrollment request. The organization is required to obtain any data necessary from the individual that it doesn't have from its data sharing.

Use of this mechanism is not required. It is up to the MA organization whether it has the capability and wants to share data between its Medicare and non-Medicare lines of business.

MA organizations may only offer simplified enrollment to individuals who:

- Are in their ICEP based on their initial enrollment in Medicare;
- Are enrolled in any type of non-Medicare plan under the same organization (or an entity under the same parent organization as the MA organization); and
- Do not have a break in coverage between the non-Medicare plan and the MA plan.

The MA organization identifies individuals who are enrolled in its non-Medicare coverage, nearing Medicare eligibility (or recently enrolled), and in their ICEP. It may conduct outreach to these current members and offer them the opportunity to enroll in their plan. Outreach efforts are considered marketing, and should clearly articulate the various plan offerings, plan structure, premium, costs, network, etc.

MA organizations may offer simplified enrollment via paper, telephone or electronically, as outlined in §§ 40.1, 40.1.1 through 40.1.3. For telephonic or electronic requests, the plan may limit the data to be collected from the applicant to those items it does not already have.

The MA organization must collect the following data for the simplified enrollment:

- Minimal personal data sufficient for the MA organization to correctly identify the current member and his or her information within its systems;

- Medicare number;
- Name of the MA plan selected for enrollment;
- Statement of a language or alternate format preference *(beneficiary response is optional; does not effect enrollment if not completed)*;
- Applicant's acknowledgement of the following items:
    - The plan has a contract with the federal government;
    - Sales agents/brokers may be compensated if they are helping the individual to enroll;
    - Release of information to Medicare and other plans, as necessary. Information may be used for research and other purposes, as allowed under federal law and regulations;
    - Obtaining benefits and services from the plan in order to be covered;
    - Maintain enrollment in both Part A and B;
    - Information provided in the enrollment request is correct; intentionally falsifying information will result in disenrollment; and
    - Understanding that completion/signature indicates an understanding of the enrollment application, and that authorized representatives have legal authority to complete the enrollment request.
- Signature or attestation of intent to enroll and, as applicable, from an authorized representative acting on the beneficiary's behalf, contact information; and
- Any other data the MA organization doesn't already have in its records that is necessary to meet the requirements in Appendix 2.

Organizations are encouraged, but are not required, to request premium payment method information in the simplified enrollment request. In the absence of a stated preference, individuals are to be placed in direct billing status, as outlined in §40.2.M. Additionally, the parameters outlined in §§ 40.1.1 through 40.1.3 must be met based on the method of the simplified enrollment request (telephonic, electronic, or paper).

Enrollments requested using this mechanism are the same as any other new ICEP enrollment the plan receives and should be processed similarly.

Example:

Mr. Smith is turning 65 in June 2018 and is enrolled in commercial coverage with an organization named Good Insurance. Good Insurance identifies in its records that Mr. Smith's Medicare Part A and B Initial Enrollment Period begins March 2018. Based on its data from Mr. Smith's commercial enrollment, Good Insurance knows that Mr. Smith lives in the service area of MA plans that Good Insurance offers.

A representative of Good Insurance calls Mr. Smith in May 2018 and identifies herself as his commercial health insurance plan. Using the plan's internal protocols, she confirm his identity on the call. In this call, she informs Mr. Smith that because he's soon to be eligible for Medicare, he can enroll in a plan that Good Insurance offers just for people with Medicare. She provides information on Good Insurance MA plans available in Mr. Smith's area and asks if he is interested in enrolling in one of these or learning more. Mr. Smith expresses his interest in enrolling in Good Insurance's MA plan with prescription drugs.

Good Insurance already has Mr. Smith's personal information via its internal systems and, while on the call, the representative obtains what is needed for the MA enrollment that Good Insurance doesn't already have. The representative uses this information to complete the telephonic enrollment request in Good Insurance's internal MA enrollment system. Good Insurance confirms the MA plan Mr. Smith

wants to enroll in and asks for his Medicare number. Good Insurance explains the legal requirements for enrollment, release of information, and confirms Mr. Smith's understanding and acknowledgement/approval to process the request. Good Insurance also provides information to Mr. Smith to process his disenrollment from the commercial coverage to be effective as of May 31, 2018.

Good Insurance processes the telephonic enrollment the same as other received requests and submits the enrollment transaction to CMS. Mr. Smith's MA plan coverage will begin on June 1, 2018, when his Medicare coverage begins.

40.2 - Processing the Enrollment Request

42 CFR 422.60
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

If an individual completes an enrollment request during a face-to-face interview, the MA organization may ask to see the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of Medicare Number, and entitlement dates for Medicare Part A and Part B. The individual does not have to show or provide the Medicare card or other evidence when submitting the request. The other forms of evidence *as listed in item "B"* are only requested when the enrollment request doesn't include the Medicare Number and the plan is unable to locate the individual in CMS systems. For processing all enrollment requests, the MA organization must verify Medicare entitlement as described in item "B" below in this section.

Appendix 2 lists all the elements that must be provided in order to consider an enrollment request "complete." If the MA organization receives an enrollment request that contains the *required* elements, the MA organization must consider the enrollment complete even if *the optional* data elements on the enrollment request are not provided. If an MA organization has received CMS approval for an enrollment request that contains data elements in addition to those included in Appendix 2, then the enrollment request is considered complete even if those additional elements are not provided.

If an MA organization receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. The MA organization must always check available systems (i.e. BEQ, MARx online query) for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the "sex" field on the enrollment *request* and the MA organization has access to this information via available systems, the organization must use that source to complete the application instead of requesting the information from the beneficiary. If the required but missing information is not available via CMS systems, the enrollment request is considered incomplete and the MA organization must follow the procedures outlined in §40.2.2 in order to complete the enrollment request.

For EGHP enrollees, the MA Organization may choose to accept enrollment requests as described in §40.1.2 or §40.1.6. All required elements as listed in Appendix 2 must be included in the record of the enrollment request provided by the group for the enrollment request to be considered complete (except signature). Follow the procedures outlined in §40.2.2 to address incomplete enrollment requests.

For *paper, telephone and electronic* enrollment requests, all required elements as listed in Appendix 2 must be included. *The "Beneficiary Signature and/or Authorized Representative Signature" element*

for a paper request is satisfied with a pen-and-ink signature, for a telephone request it is satisfied with a verbal attestation of intent to enroll, and for an electronic request it is satisfied with an electronic signature or a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool. Follow the procedures outlined in §40.2.2 to address incomplete enrollment requests.

Electronic signatures have the same legal effect and validity as pen-and-ink signatures. An MA organization utilizing electronic signatures in electronic enrollment must, at a minimum, comply with the CMS security policies. For more information on the requirements for legally binding electronic signatures, see the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §7001, and "Use of Electronic Signatures in Federal Organization Transactions" published by the CIO Council.

The following should also be considered when completing an enrollment:

A. Permanent Residence Information - The MA organization must determine whether or not the enrollee resides within the MA plan's service area. If an individual puts a Post Office Box as his or her place of residence on the enrollment request, the MA organization must consider the enrollment request incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the MA organization should consult the State law in which the MA organization operates and determine whether the enrollee is considered a resident of the State.

Refer to §10 for a definition of "evidence of permanent residence," and §20.3 for more information on determining residence for homeless individuals.

Individuals for whom the Batch Eligibility Query (BEQ) or MARx online query (M232 screen) reflects an incarcerated status*, that beneficiary is considered to* reside outside of the service area and are, therefore, not eligible to enroll.

B. Entitlement Information and Medicare Number –
42 CFR 422.50(a)(1)
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

Following the procedures outlined in the CMS Plan Communications User Guide, MA organizations must verify Medicare entitlement using the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen) for all enrollment requests, except enrollment requests from a current enrollee of an MA plan who is requesting enrollment into another MA plan offered by the same parent organization with no break in coverage (i.e. "switching plans").

Individuals are not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request. If the systems (BEQ or MARx online query) indicate that the individual is entitled to Medicare Part A and is enrolled in Part B, no further documentation of Medicare entitlement is needed from the individual.

CMS systems are updated within two business days of SSA processing new or changed Part A or Part B entitlement for a Medicare beneficiary. The CMS systems are the most up-to-date data regarding Medicare entitlement for the beneficiary.

The Medicare Number will be assigned at the time CMS first receives entitlement information for a new beneficiary. In the event that the enrollment request doesn't include the Medicare Number and the plan is unable to locate the individual in the BEQ or MARx online query, the organization should consider the enrollment request incomplete and follow § 40.2.2.

The individual may provide the Medicare Number to the organization verbally or in writing. Examples of documents the beneficiary may send to the plan which display the Medicare Number (and entitlement information) include:

- Medicare card;
- Medicare Award notice from SSA (shows Medicare entitlement dates only);
- Benefit Verification notice from SSA (includes Medicare Number and entitlement start dates);
- Medicare card information from the individual's MyMedicare.gov account; and
- A notice from CMS regarding change in Medicare Number.

NOTE: If the beneficiary provides any of the notices listed above, the date on the letter should be no more than two months before the enrollment request was received by the organization. If there is a discrepancy between the entitlement information in a document and the information in CMS' systems, use the data in CMS systems to determine eligibility for enrollment.

For auto- and facilitated enrollments, as described in §40.1.5 of this chapter, entitlement verification is deemed complete, as the individual is already an MA enrollee.

C. **Effective Date of Coverage -** The MA organization must determine the effective date of coverage as described in §30.5 for all enrollment requests. If the individual fills out an enrollment form in a face-to-face interview, then the MA organization representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the MA organization to confirm the actual effective date. The MA organization must notify the member of the effective date of coverage prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule).

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date (effective dates are described in §30.5). Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §30.5.

If a beneficiary completes an enrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must notify the beneficiary in a timely manner and explain that the enrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the notification must be documented. If

the beneficiary refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the enrollment request according to the procedures outlined in §60.2.1.

MA organizations must ensure enrollees have access to plan benefits as of the effective date of enrollment the MA organization has determined and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS systems.

For auto- and facilitated enrollments, refer to §40.1.5 of this chapter for more information.

D. **Health Related Information** - MA organizations may not ask health screening questions during completion of the enrollment request. MA organizations are only permitted to send health assessment forms after enrollment. However, MA organizations may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan, such as whether the individual is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution. Queries for this information are included on the model EGHP form in Exhibit 2. These queries are not considered to be health screening questions. The responses to these questions must not have an effect on eligibility to enroll in an MA plan.

Exception for certain MA-SNPs - An SNP that is being offered to individuals with certain medical conditions (i.e. an SNP for chronic and disabling conditions), as permitted by CMS, will need to establish that the individual has such a condition to determine eligibility for enrollment in that specific SNP. Refer to §20.11 for more information.

E. **Statements of Understanding -** As outlined in §20.5, a beneficiary must understand and agree to abide by the rules of the MA plan in order to be eligible to enroll. If the MA organization lists such statements in an itemized format, it is at the MA organization's discretion to decide whether it will:

- Consider the beneficiary signature on the form (or completion of the enrollment request process) to signify that the individual has read and understands the statements (as shown on Exhibits 1, 1b, 2 and 3); or

- Have fields next to the statements and require the applicant's initials next to each statement.

The MA organization must apply the policy consistently. If the MA organization requires the initials and the applicant fails to initial his/her understanding of each item listed on the enrollment form, the MA organization may contact the applicant to clarify the MA organization rules in order to complete the enrollment form. The MA organization must document the contact and annotate the outcome of the contact. If the MA organization is unable to contact the applicant to ensure their understanding, the enrollment form would be considered incomplete.

F. **Applicant Signature and Date -** The individual must sign the enrollment form or complete the enrollment request mechanism. If the individual is unable to do so, a legal representative must sign the enrollment form (refer to §40.2.1 for more detail) or complete the enrollment request mechanism. If a legal representative enrolls an individual, the legal representative must attest to having the authority under State law to do so, 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 individual to effect an enrollment request on behalf of the applicant is available and can be presented upon request by the MA organization or CMS.

The individual and/or legal representative must indicate his/her relationship to the individual and date he/she signed the enrollment form or completed the enrollment request; however, if he/she inadvertently fails to include the date on the enrollment request, then the date the MA organization receives the enrollment request may serve as the signature date of the form.

If a paper enrollment form is submitted and the signature is not included, the MA organization may verify with the individual 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).

Certain enrollment request mechanisms do not include a pen-and-ink, or "wet," signature. *The signature element listed in Appendix 2 is satisfied by* specific procedures provided for the other enrollment request mechanism*s* in this chapter; for example, see §40.1.*2* for information about enrollment.

For auto and facilitated enrollment as described in §40.1.5, an enrollee signature is not required.

G. Other Signatures - If the MA organization representative helps the individual fill out the enrollment form, then the MA organization representative must clearly indicate his/her name on the enrollment form. However, the MA organization representative does not have to include his/her name on the form when:

- He/she pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to him/her,
- He/she fills in the "office use only" block, and/or
- He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

The MA organization representative does have to include his/her name on the form if he/she pre-fills any other information, including the individual's phone number.

H. Old Enrollment Requests - If the MA organization receives an enrollment request that was executed more than 30 calendar days prior to the MA organization's receipt of the request, the MA organization is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

I. Determining the Application Date - The MA organization must date all enrollment requests as soon as they are initially received. Except for enrollment requests submitted via the CMS Online Enrollment Center, requests made by the group enrollment mechanism and auto or facilitated enrollments, the date the enrollment request is initially received is equivalent to the "application date" (refer to §10 for definitions of "receipt of enrollment request," "completed

enrollment request" and "application date"). If the enrollment request is not complete at the time it is received, then the additional documentation required for the enrollment request to be complete must be dated as soon as it is received. Appendix 3 describes the appropriate application date to include in the enrollment transaction submitted to CMS under various conditions.

J. Final Verification of Information - Some MA organizations verify information before enrollment information has been transmitted to CMS. In these cases the MA organization may find that it must make corrections to an individual's paper enrollment form. The MA organization should make those corrections, and the individual making those corrections must place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the MA organization (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the MA organization having to co-sign the enrollment form.

K. Premiums Owed to the MAO - For individuals enrolling in an MA-only plan, an MA organization may choose to wait for an enrolling individual's payment of the MA-only plan premium before considering the enrollment request complete. An MA organization cannot consider an enrollment request incomplete if the individual enrolling has indicated that he or she wants the plan premium withheld from an SSA benefit check.

For enrollment into either an MA-only or MA-PD plan, an MA organization may consider an enrollment request incomplete if there are premium amounts due to the organization from a prior enrollment, whether or not premium withhold from an SSA benefit check is selected.

The option chosen by the MA plan to consider the application complete or incomplete must be applied consistently to all potential enrollees of the plan.

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy

For enrollment requests submitted by dually eligible individuals and individuals who qualify for the low income subsidy (LIS), an MA organization may consider an enrollment request complete if there are premium amounts due to the organization from a prior enrollment, even if the MA organization has a policy to consider such enrollment requests incomplete.

The MA organization has the discretion to implement this exception to dually eligible individuals and individuals who qualify for LIS within each of its MA plans. If the MA organization offers this exception in one of its plans, it must apply the policy to all such individuals who request enrollment in that MA plan.

L. Completed Enrollment Requests - Once the enrollment request is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §40.6.

M. Plan Premium Payment and Premium Withhold Options –

42 CFR 422.60(c)(1)
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

MA organizations *may* include on all enrollment request mechanisms (except the simplified enrollment mechanism) the option for individuals to: 1) pay plan premiums by being billed directly by the plan or 2) have the premiums withheld from their SSA benefit check. The plan may also choose to offer other payment methods, such as automatic deduction from the individual's bank or other financial institution or from the individual's credit card. The enrollment mechanism *can* also advise that if the individual does not select a premium payment option, the default action will be direct bill.

MA-only plans that do not have a premium may omit the "Paying your Plan Premium" section from their enrollment request mechanism. MA-PD plans that do not have a plan premium *may* include, at minimum, the direct bill and SSA withhold options for those individuals subject to the LEP to select how they will pay this penalty (premium); however, such plans may *also* include introductory language to indicate that the premium payment section applies only to individuals subject to the LEP.

Railroad Retirement Board (RRB) enrollees may also submit requests to have their premiums withheld from their RRB retirement payments. Organizations *may choose to* offer this option on all enrollment mechanisms as well.

MA-PD plans *can* also include on *the* enrollment request a statement in the premium payment section advising those individuals who qualify for extra help that, if the extra help does not cover the entire plan premium, the individual is responsible for the amount that Medicare does not cover.

Model language has been provided on Exhibits 1, 1c, 3 and 3a to reflect the*se* options. In addition, suggested optional language for MA-PD plans without premiums has also been provided.

N. Additional Information for MA-PD Enrollment Requests – Individuals enrolling in a Part D plan must disclose any other existing coverage for prescription drugs.

O. U.S. Citizenship or Lawful Presence Information – MA organizations must use the CMS Batch Eligibility Query (BEQ) (individual or batch submission) or, via online access, the MARx M232 screen, to verify eligibility on the basis of incarceration status or unlawful presence status. An exception to this are enrollment requests from a current enrollee of an MA plan who is requesting enrollment into another MA plan offered by the same parent organization with no break in coverage (i.e., "switching plans").

Individuals are not required to provide evidence of U.S. citizenship or lawful presence status with the enrollment request, nor are MA organizations permitted to request such information or documentation. The systems (BEQ or MARx online query) will indicate the lawful presence status of a non-U.S. citizen, including the start and, if applicable, the end date of the unlawful presence status of the individual.

CMS eligibility queries will only reflect data for the existence of an unlawful presence status. When neither the BEQ nor the MARx online query shows any indication of unlawful presence in the U.S., the MA organization must treat the lack of information as confirmation of evidence of U.S. citizenship or lawful presence status.

When either the BEQ or the MARx online query shows an indication of unlawful presence in the U.S. and the organization receives documentation of lawful presence from the applicant, the plan cannot use this documentation to establish eligibility. If the MA organization is provided evidence of lawful presence by the applicant in the form of a document from the Department of Homeland Security or SSA and neither the BEQ nor the MARx online query reflects this lawful presence status, the organization should refer the applicant to SSA to request that SSA update its records.

40.2.1 - Who May Complete an Enrollment or Disenrollment Request

42 CFR 422.60(c)

A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MA plan. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the State in which the beneficiary resides may allow. CMS will recognize State laws that authorize persons to make such requests for Medicare beneficiaries. For example, persons authorized under State law may be 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 authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request or complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the enrollment request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, MA organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

Where MA organizations are aware that an individual has a representative payee designated by SSA to handle the individual's finances, MA organizations should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/she is the appropriate person, under State law, to execute the enrollment or disenrollment request. Representative payee status alone is not sufficient to enroll a Medicare beneficiary.

When someone other than the Medicare beneficiary completes an enrollment or disenrollment request, he or she must:

1) Attest to having the authority under State law to do so;
2) Confirm that proof of authorization, if any, required by State law that empowers the individual to make an enrollment or disenrollment request on behalf of the individual is available and can be provided upon request by CMS. MA organizations cannot require such documentation as a condition of enrollment or disenrollment; and
3) Provide contact information.

The MA organization must retain the record of this attestation as part of the record of the enrollment or disenrollment request. CMS provides a sample attestation as part of the model MA enrollment form (Exhibit 1).

If anyone has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under State law to do so, the organization should contact its CMS account manager with all applicable documentation regarding State Law and the case in question. The account manager may request supporting documentation from the individual making the election.

When an authorized representative completes an enrollment request on behalf of a beneficiary, the MA organization should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes.

40.2.2 - When the Enrollment Request Is Incomplete

42 CFR 422.50(a)(5)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

When the enrollment request is incomplete, the MA organization must document all efforts to obtain additional documentation to complete the enrollment request and have an audit trail to document why the enrollment request needed additional documentation before it could be considered complete. The organization must make this determination and, within 10 calendar days of receipt of the enrollment request, must notify the individual that additional information is needed, unless the required but missing information can be obtained via CMS systems. This notification is not required for SNP enrollment requests for which the only missing information is confirmation of the applicant's special needs status.

Note: An enrollment request is considered complete even if the only information missing is the eligibility for the election period. In such circumstances, the plan must contact the individual to assure they have a valid election period before processing the enrollment. (See Section 30 for more information regarding eligibility for election periods and Section 40 for enrollment processing requirements.)

If the request is missing the Medicare Number, see §40.2.B for more information.

If a paper enrollment form is missing a signature, see §40.2 F for more information.

For incomplete ICEP enrollment requests received prior to the month of entitlement to Part A and enrollment in Part B, additional documentation to make the request complete must be received during the first three months of the ICEP, or within 21 calendar days of the request for additional information (whichever is later). For incomplete ICEP enrollment requests received during the month of entitlement to Part A and enrollment in Part B or later, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

For incomplete AEP enrollment requests, additional documentation to make the request complete must be received by December 7, or within 21 calendar days of the request for additional information

(whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

EXAMPLES:

- Ms. Stears' 65th birthday is April 20, 2011. She is eligible for Medicare Part A and Part B beginning April 1, 2011 and has decided to enroll in Part B beginning on April 1. Her ICEP begins on January 1, 2011 and ends on July 31, 2011. She submits an incomplete ICEP enrollment request on January 15, 2011, and the MAO requests the required but missing information on January 20, 2011. The enrollment request must be denied if the required information is not received by March 31, 2011.

- Ms. Mohan's 65th birthday is June 10, 2011. She is eligible for Medicare Part A and Part B beginning June 1, 2011 and has decided to enroll in Part B beginning on June 1. Her ICEP begins on March 1, 2011 and ends on September 30, 2011. She submits an incomplete ICEP enrollment request on July 5, 2011, and the MAO requests the required but missing information on July 7, 2011. The enrollment request must be denied if the required information is not received by July 31, 2011.

When the MA organization receives an incomplete enrollment request near the end of either a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission "cut-off" date (these dates are provided in the CMS Plan Communications User Guide). MA organizations may utilize a code 61 enrollment transaction to directly submit the request to CMS as provided in the CMS Plan Communications User Guide.

If additional documentation needed to make the enrollment request "complete" is not received within allowable time frames, the organization must deny the enrollment using the procedures outlined in §40.2.3.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment request, the MA organization must contact the individual to request the information within ten calendar days of receipt of the enrollment request. The organization may contact the beneficiary either in writing (see Exhibit 5 for a model letter) or orally. If the contact is made orally, the MA organization must document the contact and retain the documentation in its records. The MA organization must explain to the individual that s/he has 21 calendar days in which to submit the additional information or the enrollment will be denied. Since an incomplete enrollment request is an invalid enrollment (as explained in §40.6), if the additional documentation is not received within allowable time frames, the MA organization must send a denial of enrollment letter (see Exhibit 7).

If all documentation is received within allowable time frames and the enrollment request is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4.

40.2.3 - MA Organization Denial of Enrollment

MA organization denials occur before the organization has transmitted the enrollment to CMS. For enrollment requests that do not require additional information from the applicant, an MA organization

must deny an enrollment within 10 calendar days of receiving the enrollment request based on its own determination of the ineligibility of the individual to elect the MA plan. For an incomplete enrollment request that requires information from the applicant and for which the applicant fails to provide the information within the required time frame, an MA organization must deny the enrollment within 10 calendar days of the expiration of the time frames described in §40.2.2.

Notice Requirement - The organization must send notice of the denial to the individual that includes an explanation of the reason for denial (refer to Exhibit 7 for a model notice). This notice must be sent within ten calendar days of either 1) receipt of the enrollment request or 2) expiration of the time frame for receipt of requested additional information, as described in the following examples:

- An MA organization receives an enrollment request from an individual on November 7 and determines on that same day that the individual is ineligible due to place of residence. The organization should send notice of denial within ten calendar days from November 7.

- An MA organization receives an enrollment request from an individual on January 7 and is unable to determine, through direct contact with the beneficiary or the beneficiary's authorized representative, that the beneficiary has a valid enrollment period available. The organization should send notice of denial within ten calendar days from January 7.

- An MA organization receives an enrollment form on November 7 from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information, on November10. The beneficiary does not submit the information by December (as required under §40.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within ten calendar days from December 1.

40.2.4 - MA-PD Enrollment When an Individual has Other Qualified Prescription Drug Coverage through an Employer or Union Retiree Drug Subsidy (RDS) Plan Sponsor

CMS systems will compare MA-PD enrollment transactions to information CMS has regarding the existence of employer or union sponsored qualified prescription drug coverage for which the beneficiary is also being claimed for the Retiree Drug Subsidy (RDS). If there is a match indicating that the individual may have such other coverage, the enrollment will be conditionally rejected by CMS systems as incomplete.

Within 10 calendar days of receipt of the Code 127 conditional rejection, the MA organization must contact the individual to confirm the individual's intent to enroll, and that the individual has discussed and understands the implications of enrollment in a Part D plan on his or her employer or union coverage. Individuals will have 30 calendar days from the date they are contacted to respond. The organization must ensure that plan benefits are available to the individual as of the effective date of the initial enrollment request and must not delay the provision of plan benefits in anticipation of the applicant's confirmation of intent to enroll. The organization may contact the individual in writing (See Exhibit 6b) or by phone and must document this contact and retain it with the record of the individual's enrollment request. If the individual indicates that s/he is fully aware of any consequence to his/her employer or union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the MA organization must update the transaction with the appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and re-submit it for

enrollment. The effective date of enrollment will be based upon the individual's initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date. MA organizations may use the Code 61 enrollment transaction code to submit the enrollment transaction directly to CMS, as described in the Plan Communication Users Guide (PCUG).

MA organizations are strongly encouraged to closely monitor their outreach efforts and to follow up with applicants prior to expiration of the 30 day timeframe. If the individual does not respond in 30 days, or responds and declines the enrollment, the enrollment must be denied. A denial notice must be provided (see Exhibit 7).

When an employer or union sponsored MA-PD plan is replacing an existing RDS plan offered by that employer or union group, the MA organization may receive the Code 127 conditional rejection. In these cases, it is not necessary to contact each individual, as described above. The MA organization must resubmit the transactions updated with the appropriate flag.

MA organizations should work in close collaboration with employer/union sponsors who are replacing RDS coverage with Part D coverage to ensure that all individuals are aware of the change and have the information they need.

40.3 - Transmission of Enrollments to CMS

For all enrollment requests effective January 1, 2008, or later that the organization is not denying per the requirements in §40.2.3, the MA organization must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the MA organization within 7 calendar days of receipt of the **completed** enrollment request. CMS system "down" days are included in the calculation of the 7 calendar days (refer to Appendix C of the Plan Communications User Guide). For the purpose of assessing compliance with this requirement, CMS will count the enrollment request receipt date as "day zero" and the following day as "day one." In the case of enrollment requests that are accepted after the MA organization is enrolled to capacity, but as a vacancy occurs, the MA organization must submit the information within 7 calendar days after a vacancy has become available.

All enrollment elections must be processed in chronological order by date of receipt of completed enrollment elections (refer to §40.5 for procedures when the MA plan is closed for enrollment).

MA organizations are encouraged to submit transactions by the earliest possible MA organization processing cutoff date (refer to the Plan Communications Users Guide (PCUG)). However, if the organization misses the cutoff date, it must still submit the transactions within the required 7 calendar day time frame.

> **NOTE:** The requirement to submit the transaction within 7 calendar days does not affect the effective date of the individual's coverage under the plan, i.e., the effective date must be established according to the procedures outlined in §§30.5 and 30.7.

More detail on how MA organizations must submit transmissions to CMS are contained in the Medicare Advantage and Prescription Drug Plans Plan Communications User Guide.

40.4 - Information Provided to Member

Much of the enrollment information that an MA organization must provide to the member must be sent prior to the effective date of coverage. However, some information will be sent after the effective date of coverage. A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.

As discussed previously (§40), the organization must provide required notices in response to information received from CMS on the *D*TRR that provides the earliest notification. Organizations may choose to send notifications based on the availability of each Batch Completion Summary Status (BCSS) file if they desire. However, in no case may use of the BCSS for this purpose extend any timeframe established in this guidance. Organizations choosing to utilize the BCSS for certain required beneficiary notifications must do so consistently.

The organization may provide the required notices described in §§40.4.1 and 40.4.2 or may utilize a single ("combination") notice (see Exhibits 4b and 4e). The combination notice takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance. To use the combination notice, the organization must be able to provide this notice within 7 calendar days of the availability of the *D*TRR. Additionally, when following this option to use the combination notice, if the organization is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end of the month), the organization still must ensure that the beneficiary has the information required in §40.4.1 within the timeframes described therein.

If an individual's enrollment includes a request for SSA or RRB premium withhold and was processed after the monthly cut-off for payment, the organization must submit the request for premium withhold separate from the enrollment request. Plans should resubmit the request for premium withhold timely to assure the individual can have premium withholding at the next possible effective date. Additionally, the organization must inform the individual that:

- If his/her request for premium withholding is approved, it will start in 1-2 months;
- The effective date for premium withholding will not be retroactive;
- S/he will be responsible for paying the organization directly for all premiums due from the enrollment effective date until the month in which premium withholding begins; and
- For plans implementing §50.3.1, failure to pay premiums for months in which premium withholding is not in effect will result in disenrollment from the plan.

40.4.1 - Prior to the Effective Date of Coverage

42 CFR 422.6*0*(e)
(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Prior to the effective date of coverage, the MA organization must provide the member with all the necessary information about being a Medicare member of the MA organization, the MA organization

rules, and the member's rights and responsibilities (an exception to this requirement is described in §40.4.2). The MA organization must also provide the following to the individual:

- For enrollment requests submitted via electronic enrollment or telephonic enrollment mechanisms (including the simplified enrollment mechanism), evidence that the enrollment request was received (e.g., a confirmation number). For paper enrollment requests, organizations are not required to provide evidence of receipt outside of the acknowledgement or combination notice outlined below. Organizations may choose to provide a confirmation number or other tracking mechanism indicating receipt of the paper enrollment request. However, organizations are expected to keep a copy of the paper enrollment form and provide a copy upon request by the beneficiary.

- A notice acknowledging receipt of the completed enrollment request (refer to Exhibits 4, 4a, and 4c for model letters) and showing the effective date of coverage. This notice must be provided no later than 10 calendar days after receipt of the completed enrollment request (organizations choosing to use the combination notice, refer to 40.4 above).

- Proof of health insurance coverage so that he/she may begin using plan services as of the effective date. This proof must include the 4Rx data necessary to access benefits.

  NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the Medicare Communications and Marketing Guidelines. The proof of coverage may be in the form of member ID cards, the enrollment form, and/or a notice to the member (refer to Exhibits 4, 4a, 4b and 4c, which are model letters with optional language that would allow the member to use the letter as evidence of health insurance coverage until he/she receives a member card). As of the effective date of enrollment, plan systems should indicate active membership.

Regardless of whether an enrollment request is made in a face-to-face interview, by fax, by mail, or by other mechanisms defined by CMS, the MA organization must explain:

- The charges for which the prospective member will be liable, e.g., any premiums (this includes any Part D late enrollment penalty), coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance, if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).

- The prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.

- The lock-in requirement. The MA organization must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care.

- The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B at the time coverage begins and he/she has used MA plan services after the effective date.

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the MA organization has not yet provided the ID card).

40.4.2 - After the Effective Date of Coverage

42 CFR 422.62(e)
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

The CMS recognizes that in some instances the MA organization will be unable to provide the materials and required notifications to new enrollees prior to the effective date, as required in §40.4.1. These cases will generally occur when an enrollment request is received late in a month with an effective date of the first of the next month. In these cases, the MA organization still must provide the member all materials described in §40.4.1 no later than 10 calendar days after receipt of the completed enrollment request. Additionally, the MA organization is also strongly encouraged to call these new members as soon as possible (such as within 1-3 calendar days) to provide the effective date, the information necessary to access benefits and to explain the MA organization rules. The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

Acceptance/Rejection of Enrollment

Once the MA organization receives a *D*TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the MA organization must notify the individual in writing of CMS' acceptance or rejection of the enrollment within ten calendar days of the *D*TRR that contains the earliest notification of the acceptance or rejection (see Exhibits 4d, 6, 6a, 6c, 6d and 8 for model letters). The enrollment confirmation notice must explain the charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.

There are exceptions to this notice requirement for certain types of transaction rejections. These exceptions exist so as not to penalize the individual for a systems issue or delay, such as a plan transmission or keying error. In this case, the MA organization should not send a rejection notice and must request a retroactive enrollment from CMS (or its designee) within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. If CMS (or its designee) is unable to process the retroactive enrollment due to its determination that the individual is not eligible, the MA organization must notify the individual of the rejection in writing within ten calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §60.4.

If an MA organization rejects an enrollment and later receives additional information from the individual substantiating his/her eligibility, the MA organization must obtain a new enrollment request from the individual in order to enroll the individual and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §60.4 for more information regarding retroactive enrollments.

40.5 - Enrollment Processing During Closed Periods

42 CFR 422.60(a)(2) and 422.60(b)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

As described in §40.3, an MA organization must process elections in order by date of receipt of completed enrollment election when it is open for enrollment. However, an MA organization may close an MA plan to OEP and OEPI enrollments or when it reaches a CMS-approved capacity limit. This section addresses procedures for handling enrollment requests that arrive at the MA organization when an MA plan is closed for enrollment, either through voluntary closure to OEP and OEPI enrollments or because a CMS-approved capacity limit has been reached, and for processing those enrollments when the MA plan re-opens or a vacancy occurs.

If an MA organization believes its MA plan does not have the capacity to accept additional members, or as the MA plan enrollment grows and the MA organization estimates it may reach capacity during its next open enrollment period, the MA organization may request a CMS-approved limit on enrollment.

A capacity limit allows an MA organization to close or limit enrollment for all election periods. Only with a reserved vacancy may an MA organization set aside vacancies for enrollment of conversions.

40.5.1 - Procedures After Reaching Capacity Limit

42 CFR §§ 422.60(a)(2) and 422.60(b)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

If the number of individuals who elect to enroll in an MA plan exceeds a CMS-approved capacity limit, then the MA organization may limit enrollment of these individuals, but only if it provides priority in acceptance.

If an MA organization receives completed enrollment requests between the time it reaches its limit and the time CMS approves the limit, it may follow one of two options **after it receives approval from CMS to limit enrollment:** (1) Deny the enrollment due to the onset of the capacity limit, or (2) Place the enrollment on a waiting list to be processed as vacancies occur in the priority of acceptance. This priority requires that the MA organization process enrollments from individuals who elected the MA plan prior to CMS' determination that the capacity has been exceeded, in order based on date of receipt of the completed enrollment request, and in a manner that does not discriminate on the basis of any factor related to health as described in 42 CFR §422.110.

The MA organization must take the same action for all enrollment requests received. See below for procedures for following options 1 or 2.

After the enrollments discussed in the above paragraph are acted upon, the MA organization has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The MA organization may follow one of two options: (1) Deny the enrollment due to the capacity limit, or (2) Place the enrollment on a waiting list to be processed when the plan re-opens for enrollment. However, to ensure no discrimination is applied to applications processed, all MA organizations that use option 1 (i.e., deny enrollment) for enrollments discussed in the above paragraph, must continue to deny all enrollments received while the plan is closed for enrollment, and may not use option 2. The MA organization must take the same action for all enrollment forms received. In the case of enrollments received after the plan closes for enrollment, the date the MA plan re-opens becomes the "receipt date" of enrollment forms received when the plan was closed.

EXAMPLE: If the plan was closed in April and re-opens on May 1, then the receipt date of enrollment requests received in April is May 1. See below for procedures for following options 1 or 2.

If the MA Organization Uses Option 1 - It must notify the individual in writing that it is denying the enrollment, and should do so within ten calendar days after it receives the enrollment request or after the MA organization receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

If the MA Organization Uses Option 2 - It must notify the individual in writing that he/she has been placed on a waiting list, and should do so within ten calendar days after the MA organization receives the enrollment request or after the MA organization receives approval from CMS to limit enrollment. The notice must also provide an estimated length of time that the individual will be on a waiting list and instruct the individual that he may cancel his enrollment before a vacancy occurs.

As enrollment spaces become available, if the plan was closed for more than 30 calendar days since the receipt of the enrollment form, the MA organization must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) Within ten calendar days after contacting the individual, the MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc.

There may be situations in which the MA organization has closed enrollment in a service area, yet receives an approval for a capacity limit for a portion of that same service area. Given that MA plans are either open or closed to OEP and OEPI enrollments for an ENTIRE plan service area, any vacancies which may open up may only be filled by individuals making AEP, ICEP or SEP enrollment elections by applying the rules for accepting enrollments when MA plans are closed (see §40.5.2 below). Further, it must take those individuals based upon enrollments received in chronological order.

40.5.2 - Procedures After Closing During the OEP and OEPI

42 CFR §§ 422.60(a)(2) and 422.60(b)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

As stated in §30, an MA organization must accept all enrollment requests for its MA plans made during the AEP, ICEP, or SEP. However, an MA organization may not process OEP or OEPI enrollments for a plan when the plan is closed to OEP and OEPI enrollments.

If an MA plan is closed to OEP and OEPI enrollments and receives new OEP or OEPI enrollment requests or documentation to complete OEP enrollment requests already received by the MA

organization, then the MA organization may do one of the following. The MA organization must take the same action for all enrollment forms received while the plan is closed:

1. Deny the enrollment;
2. Continue to accept the completed enrollment requests to be placed on a waiting list.

If the MA Organization uses option #1 above - It must notify the individual in writing that it is denying the enrollment, and should do so within ten calendar days after it receives the enrollment request (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

If the MA Organization uses option #2 above - it must notify the individual in writing that he or she has been placed on a waiting list. The notice must inform the individual that the enrollment request will not be processed until the plan re-opens for enrollment, must include the date the plan will re-open, and must inform the individual that he or she may cancel the request for enrollment before the plan re-opens. All individuals who wish to wait for an opening must be placed on the waiting list.

After the MA plan re-opens, if the plan was closed for more than 30 calendar days since the MA organization received the enrollment request, it must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) The MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan, and should do so within ten calendar days after contacting the individual.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc. The date the MA plan re-opened becomes the "receipt date" of enrollment forms received when the plan was closed.

> **EXAMPLE:** If the plan was closed in February and re-opens on March 1, then the receipt date of enrollment requests received in February is March 1.

40.6 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive cancellation of enrollment action may be necessary (refer to §60.5 for more information on retroactive disenrollments). In addition, a reinstatement to the plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his/her original plan of choice.

An enrollment that is not complete, as defined in §10, is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if an MA organization determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the MA plan's service area. A second example could be an instance

where an individual not authorized by State law to make an enrollment request on another's behalf attempts to complete an enrollment request.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, CMS does not regard an enrollment as actually complete if the member or his/her legal representative did not intend to enroll in the MA organization. If there is evidence that the individual did not intend to enroll in the MA organization, the MA organization should submit a retroactive disenrollment request to CMS. Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should have signed for the individual;
- Request by the individual for cancellation of enrollment before the effective date (refer to §60.2 for procedures for processing cancellations);
- Enrolling in a supplemental insurance program immediately after enrolling in the MA organization; or
- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the individual may believe that he/she was purchasing a supplemental health insurance policy, as opposed to enrolling in an MA organization. In addition, use of an MA plan doctor does not necessarily indicate an understanding of the lock-in requirement if the doctor also treats non-plan members.

40.7 - Enrollment Procedures for Medicare MSA Plans

MA organizations offering a Medicare MSA plan must follow the procedures outlined in §§40.2, 40.3, 40.4, 40.5.1, and 40.6. MSA plans must have a paper enrollment form available for eligible individuals to request enrollment. Exhibit 1b is a model MSA plan enrollment form. Organizations may use this model form as it appears or may customize their enrollment forms based on this model, if they follow usual Medicare marketing material approval practices and ensure all the required MSA specific elements are included. Applications for Medicare MSAs must include a question regarding election of the Medicare hospice benefit.

All information necessary to successfully enroll the individual in the MSA plan must be provided to consider the enrollment request complete, including the answers to questions 1 – 4 on the model MSA enrollment form. Additionally, the organization must obtain the necessary banking and account information before the enrollment can be considered complete. The MA organization must ensure its materials describing the MSA plan explain the details of having the MSA account and what options the individual will have regarding the account.

Beneficiaries may enroll into a Medicare MSA plan only through the MA organization offering that plan. Beneficiaries may enroll directly with the plan by completing an approved paper enrollment form. Additionally, MSA plans may offer an online enrollment mechanism as defined in §40.1.2 through the organization's website. MSA plans are not available through the Online Enrollment Center on the Medicare.gov website.

40.7.1 - Establishing the MSA Banking Account during the Enrollment Process

Medicare beneficiaries interested in enrolling in a MSA plan will need to establish an MSA bank account to accept MSA deposits in accordance with the MSA plan's procedures. The MA Organization must have documentation that a beneficiary will open the MSA account before submitting an enrollment transaction to MARx for that beneficiary. CMS will make the annual deposit payment to the plan on the same schedule as the monthly capitation payment. Per Section 1853(e)(2) of the Act, payment of an MSA deposit cannot be made until the beneficiary account has been established.

Acceptable documentation that an MSA account has been established includes a written/electronic notice from the bank that the beneficiary has opened an MSA account, or a written/electronic communication from the beneficiary that the MSA account has been opened, with the bank routing number and account number reported on the communication. The MSA organization must retain this documentation. Described below are several procedures that the MSA Organization could implement to facilitate the establishment of these MSA accounts:

1. The organization provides the beneficiary with specific banking enrollment materials to begin the process necessary for establishment of the MSA banking account. The specified bank supplies the beneficiary with the required signature card and items needed for establishing the account. The beneficiary completes and returns the required documents to the specified bank. The bank provides the information to the MSA plan to complete the enrollment transaction.

2. For an employer/union sponsored MSA plan, the plan's designated bank deals directly with the employer or union allowing the employer or union to facilitate the establishment of an account on behalf of the Medicare beneficiaries enrolling in the MSA plan.

Finally, these procedures must accommodate the following guidance:

- MSA organizations must educate beneficiaries that the enrollment is not complete until the MSA account is set up.
- The organization must have documentation that the account has been established prior to submitting the enrollment transaction to CMS.
- MSA organizations must educate beneficiaries that once the enrollee's initial deposit has been received in the MSA account the enrollee may then transfer the funds to his or her own banking institution.

MARx will not reject an MSA enrollment transaction if CMS records show an open period of Medicaid or Hospice coverage; however, MARx will provide information about these statuses. MSA plans should contact the beneficiary to confirm or deny this information.

50 - Disenrollment Procedures

42 CFR 422.74

Except as provided for in this section, an MA organization may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While an MA organization may contact members to determine the reason for disenrollment, the MA organization must not discourage members from disenrolling after they indicate their desire to do so. The MA organization must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

All notice requirements are summarized in Appendix 1.

NOTE: It is not necessary for an MA plan to send a notice of disenrollment to beneficiaries whose plan benefit package (PBP) number is changed as part of a CMS-approved plan renewal. The annual notice of change that the MA organization sends to the beneficiaries as part of the end-of-year activities serves this function. Instructions and information on the annual notice of change can be found in§60.7 of Chapter 3 of the Medicare Managed Care Manual.

50.1 - Voluntary Disenrollment by Member

A member may request disenrollment from an MA plan only during one of the election periods outlined in §§30 and 30.7. The member may disenroll by:

1. Enrolling in another plan (during a valid enrollment period);
2. Giving or faxing a signed written notice to the MA organization, or through his/her employer or union, where applicable;
3. Submitting a request via the Internet to the MA organization (if the MA organization offers such an option); or
4. Calling 1-800-MEDICARE.

If a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. The MA organization may send a disenrollment form to the member upon request (see Exhibits 9, 9a, and 10).

The disenrollment request must be dated when it is initially received by the MA organization.

Per §40.2.1, when someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

1. Attest that he or she has the authority under State law to make the disenrollment request on behalf of the individual;
2. Attest that proof of this authorization (if any), as required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available upon request by the MA organization or CMS; and
3. Provide contact information.

50.1.1 – Requests Submitted via Internet

The MA organization has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The MA organization must, at a minimum, comply with the CMS security policies - found at http://www.cms.hhs.gov/informationsecurity/. However, the MA organization may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies require MA organizations to provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the MA organization is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the MA organization to ascertain whether it is in compliance with the security policy. The effective date of the request is determined by the election period in which the valid request was received by the MA organization. The election period is determined by the date the request is received at the site designated by the MA organization, as described in member materials.

The option of online disenrollment is limited to requests submitted via the MA organization's website. Online disenrollment via other means, such as a broker website, as well as disenrollment requests submitted via email, are not permitted.

50.1.2 - Request Signature and Date

When providing a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §40.2.1 for more detail on who may complete enrollment and disenrollment requests). If a legal representative signs the request for the individual, then he or she must attest to having the authority under State law to do so, 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 individual to effect a disenrollment request on behalf of the applicant is available and can be presented upon request to the MA organization or CMS.

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the MA organization places on the request form will serve as the signature date.

If a written disenrollment request is received and the signature is not included, the MA organization may verify with the individual or legal representative with a phone call and document the contact, rather than return the written request as incomplete.

50.1.3 - Effective Date of Disenrollment

The election period during which the organization received a valid request to disenroll will determine the effective date of the disenrollment; refer to §§30.6 and 30.7 for information regarding disenrollment effective dates.

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date. Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §§30.6 and 30.7.

If a beneficiary submits a disenrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must call or write the beneficiary to explain that the disenrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the call must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary can cancel the disenrollment request according to the procedures outlined in §60.2.2.

50.1.4 - Notice Requirements

After the member submits a request, the MA organization must provide the member with a disenrollment notice within ten (10) calendar days of receipt of the request to disenroll. The disenrollment notice must include an explanation of the lock-in restrictions for the period during which the member remains enrolled in the organization, and the effective date of the disenrollment (see Exhibit 11). The MA organization may also advise the disenrolling member to hold Original Medicare claims for up to one month so that Medicare computer records can be updated to show that the person is no longer enrolled in the plan. For these types of disenrollments, i.e., disenrollments in which the member has disenrolled directly through the MA organization, MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment notice after receiving CMS confirmation of the disenrollment from the *D*TRR.

Since Medicare beneficiaries have the option of disenrolling through sources other than the MA organization (such as 1-800-MEDICARE or by enrolling in another Medicare managed care plan or PDP), the MA organization will not always receive a request for disenrollment directly from the member and will instead learn of the disenrollment through the CMS *D*TRR. If the MA organization learns of the voluntary disenrollment from the CMS *D*TRR (as opposed to through written request from the member), the MA organization must send a written confirmation notice of the disenrollment to the member within ten calendar days of the availability of the *D*TRR (see Exhibit 12). Organizations may choose, but are not required, to issue a disenrollment confirmation notice for an automatic disenrollments resulting from an individual's enrollment in a PBP within the same MA contract.

If the MA organization receives a disenrollment request that it must deny, the organization must notify the enrollee within 10 calendar days of the receipt of the request, and must include the reason for the denial (see Exhibit 12a).

An MA organization may deny a voluntary request for disenrollment only when:

1. The request was made outside of an allowable period as described in §30 of this guidance; or
2. The request was made by someone other than the enrollee and that individual is not the enrollee's legal representative (as described in §40.2.1).
3. The request was incomplete and the required information is not provided within the required time frame (as described in §50.4.2).

50.1.5 - Optional Employer/Union MA Disenrollment Request Mechanism

As described in §20.4.1 of this chapter, beginning April 1, 2003, MA organizations that offer employer or union group-sponsored MA plans may choose to accept voluntary disenrollment requests from beneficiaries enrolled in those plans directly from the employer or union (or its TPA) without obtaining a written disenrollment request from each individual. The disenrollment must be prospective from the date the request is received by the employer/union group.

- The MA organization must inform its Regional Office Account Manager of its intent to use this mechanism and identify the employer(s) or union(s) for which it will be accepting disenrollments made in this manner.

- The disenrollment information (i.e., the electronic file) submitted to the MA organization by the employer or union (or TPA) must accurately reflect the employer's or union's record of the disenrollment made by each individual according to the processes the employer or union has in place, and may be accepted without a paper MA disenrollment request form.

- This alternate disenrollment request mechanism is used in place of paper MA disenrollment request forms and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the MA organization receipt date will be the date the employer's or union's record of an individual's disenrollment choice is received by the MA organization. MA organizations must record these dates.

- Effective date calculation of voluntary disenrollments and the collection and submission of disenrollments to CMS will follow existing procedures.

- To accept electronic records of employer or union disenrollment requests, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information.

- The employer's or union's record of the disenrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS as necessary, and be maintained (by the employer/union or the MA organization, as they agree) for at least 6 years following the effective date of the individual's disenrollment from an MA plan. The MA organization must maintain its record of information received from the employer or union following the guidelines for MA disenrollment request forms (see §60.9).

50.1.6 - Group Disenrollment for Employer/Union Sponsored Plans

CMS is providing a process for group disenrollment from an employer or union sponsored MA plan. CMS will allow an employer or union to disenroll its retirees from an employer or union sponsored MA plan using a group disenrollment process.

The group disenrollment process must include notification to each beneficiary as follows:

- All beneficiaries must be notified that the employer or union intends to disenroll them from the MA plan that the employer or union is offering; and
- This notice must be provided by the MA organization, employer, or union not less than 21 calendar days prior to the effective date of the beneficiary's disenrollment from the employer/union sponsored MA plan.

Additionally, the information provided must include an explanation on how to contact Medicare for information about other MA plan options that might be available to the beneficiaries.

The employer/union must have and provide all the information required for the MA organization to submit a complete disenrollment request transaction to CMS, as described in this and other CMS MA systems guidance. Records must be maintained as outlined in §60.9 of this chapter.

50.1.7 - Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll from the MA plan and into Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that s/he disenrolled as a result of an SEP and is eligible for such guaranteed issue rights. A beneficiary may contact the MA organization for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2 - Required Involuntary Disenrollment

The MA organization **must** disenroll a member from an MA plan in the following cases. Refer to §50.6 for some exceptions to required disenrollment for grandfathered members.

1. A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in the plan (§50.2.1);
2. The member loses entitlement to either Medicare Part A or Part B (§50.2.2);
3. The SNP enrollee loses special needs status and does not reestablish SNP eligibility prior to the expiration of the period of deemed continued eligibility (§20.11).
4. The member dies (§50.2.3);

5. The MA organization contract is terminated, or the MA organization reduces its service area to exclude the member. There is an exception to this rule, which is described in §50.2.4;
6. The member fails to pay his or her Part D-IRMAA to the government and CMS notifies the plan to effectuate the disenrollment (§50.2.6); or
7. The member is not lawfully present in the United States (§50.2.7).

Incarceration – A member who is incarcerated resides outside the plan's service area, even if the correctional facility is located within the plan's service area (see §10 for definition of "incarcerated").

Notice Requirements - Disenrollment notices must be sent when:

- The individual has a change in residence and is determined to be out of the plan's service area;
- CMS disenrolls the individual due to incarceration;
- The individual loses SNP status and doesn't regain eligibility within the period of continued deemed eligibility;
- The individual loses eligibility for enrollment due to contract termination or service area reduction by the MA organization; or
- CMS disenrolls the individual for non-payment of Part D-IRMAA.

For disenrollments effectuated by the MA organization, all disenrollment notices must:

1. Advise the member that the MA organization is planning to disenroll the member and why such action is occurring;

2. Be mailed to the member before submission of the disenrollment transaction to CMS; and

3. Include an explanation of the member's right to a hearing under the MA organization's grievance procedures. (This explanation is not required if the disenrollment is a result of the MA plan termination or service area or continuation area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and service area reductions, which are provided in separate instructions to MA organizations.)

For disenrollments effectuated by CMS due to incarceration or nonpayment of Part D-IRMAA, the disenrollment notice must advise the member that the plan has disenrolled him or her, why such action is occurring and be mailed within ten (10) calendar days of receiving the disenrollment *D*TRR from CMS.

Plans are strongly encouraged, but not required, to send notices for certain CMS-effectuated disenrollments, including:

- Death (Exhibit 13);
- Loss of entitlement (Exhibit 14); and
- Unlawful presence in the United States (Exhibit 38).

For plans that provide disenrollment notices for these situations, the disenrollment notices should advise the member that the plan has disenrolled him or her and why such action is occurring. Plans are encouraged to mail these notices within ten (10) calendar days of receiving the disenrollment *D*TRR from CMS.

Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2.1 - Members Who Change Residence

MA organizations may offer (or continue to offer) extended "visitor" or "traveler" programs to members of coordinated care plans who have been out of the service area for up to 12 months. The MA organizations that offer such programs do not have to disenroll members in these extended programs who remain out of the service area for more than 6 months but less than 12 months. As mentioned at 42 CFR 422.74(d)(4)(iii), MA organizations offering a plan with a visitor/traveler program must make this option available to all enrollees who are absent for an extended period from the MA plan's service area. However, MA organizations may limit this option to enrollees who travel to certain areas, as defined by the MA organization, and who receive services from qualified providers. Organizations offering MA-PFFS plans may allow continued enrollment of individuals absent from the plan service area for up to 12 months, given that PFFS plans provide access to plan benefits and services from providers located outside the plan service area.

MA organizations offering plans without these programs must disenroll members who have been out of the service area for more than 6 months.

An SEP, as defined in §30.4.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another MA or Part D plan (either a PDP or MA-PD) during this SEP.

50.2.1.1 - General Rule

The MA organization must disenroll a member if:

1. He/she permanently moves out of the service area and his/her new residence is not in a continuation area;

2. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds 6 consecutive months;

3. The member is enrolled in an MA plan that offers a visitor/traveler program and his/her temporary absence exceeds 12 consecutive months (or the length of the visitor/traveler program if less than 12 months);

4. The member is an out-of-area member (as defined in §10), and permanently moves to an area that is not in the service area or continuation area;

5. He/she permanently moves out of the continuation area of an MA local plan and his/her new residence is not in the service area or another continuation area of the MA local plan;

6. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members in MA local plans) and into a continuation area, but chooses not to continue enrollment in the MA local plan (refer to §60.7 for procedures for choosing the continuation of enrollment option);

7. The member is an out-of-area member (as defined in §10), who leaves his/her residence for more than 6 months;

8. The member is incarcerated and, therefore, resides out of area for the duration of the incarceration.

50.2.1.2 - Effective Date of Disenrollment

Generally disenrollments for **reasons 1, 4, 5, 6 and 8** above are effective the first day of the calendar month after the date the member begins residing outside of the MA plan's service area (or continuation area, as appropriate) AND after the member or his or her legal representative notifies the organization that he or she has moved and no longer resides in the plan service area. In the case of an individual who provides advance notice of the move, the disenrollment will be the first of the month following the month in which the individual indicates he or she will be moving.

In the case of incarcerated individuals, CMS will involuntarily disenroll individuals who are incarcerated based on data CMS receives from SSA. CMS will report the disenrollments to the organization via the daily *D*TRR using a specific Transaction Reply Code (TRC). For all such disenrollments, the effective date of disenrollment will be the first of the month after the incarceration start date.

MA organizations may receive notification of the individual's possible incarceration status via another source. In this situation, the MA organization needs to investigate and, following processes in §50.2.1.3, determine if the member resides in the plan's service area and, if appropriate, involuntarily disenroll the member. If the incarceration information is received from a public entity or other source with direct access to confirmed incarceration data, such as a penal facility, state Medicaid agency or other state or federal agency, additional investigation is not necessary. Disenrollment is effective the first of the month following the organization's confirmation of a current incarceration. The MA organization is required to send notification of the disenrollment to the member.

If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first of the month after the move), the MA organization can submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment for **reasons 2 and 7** above is effective the first day of the calendar month after 6 months have passed. Disenrollment for **reason 3** is effective the 1st day of the 13th month (or the length of the visitor/traveler program if less than 12 months) after the individual left the service area.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change to enrollment in Original Medicare.

50.2.1.3 - Researching and Acting on a Change of Address

Within ten (10) calendar days of receiving a notice of a change of address or an indication of possible out-of-area residency from the member, the member's legal representative, a CMS *D*TRR, or another source, the MA organization must make an attempt to contact the member to confirm whether the move is permanent (may use Exhibit 34 if contacting the member in writing). The MA organization must also document its efforts. The requirement to attempt to contact the member does not apply to a prospective enrollment for which the organization receives either transaction reply code 011 (Enrollment Accepted) or 100 (PBP Change Accepted as Submitted) accompanied by 016 (Enrollment Accepted – Out of Area) on the same *D*TRR, as these represent new enrollments for which the organization recently confirmed the individual's permanent residence in the plan service area. MA organizations may obtain either written or verbal verification of changes in address, as long as the MA organization applies the policy consistently among all members.

In the case of individuals for which the plan learns of possible incarceration status from a source other than CMS, the MA organization must confirm the individual's out of area (i.e., incarcerated) status. Confirmation may include contacting the individual or other sources to determine confirmation of incarceration and incarceration start and end dates, if applicable. As described in §50.2.1.2, additional investigation is not necessary if the incarceration information is received from a public entity or other source with direct access to confirmed incarceration data. When an organization is notified of a current member's past period of incarceration and has confirmed that this member's period of incarceration has ended (i.e. individual is no longer incarcerated), the organization must continue the individual's enrollment, unless otherwise directed by CMS.

If the MA organization confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the organization must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If the MA organization confirms an individual's current incarceration status as well as the start date of the current incarceration, the organization must disenroll the individual for the first of the month following the start date of the incarceration. If that disenrollment effective date is outside the range of effective dates allowed by MARx (based on the current calendar month), the MA organization must submit the retroactive disenrollment request to the CMS Retroactive Processing Contractor (see §60.5).

The MA organization must retain documentation from the member or member's legal representative of the notice of the change in address, including the determination of whether the member's out-of-area status is temporary or permanent.

1. If the MA organization receives notice of a **permanent change** in address **from the member or the member's legal representative**, and the new address is outside the MA plan's service

area (or continuation area, for continuation of enrollment members), the MA organization must disenroll the member and provide proper notification (Exhibit 36). The only exception is if the member has permanently moved into the continuation area and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.8).

2. If the MA organization receives notice (or indication) of a potential change in address **from a source other than the member or the member's legal representative**, and the new address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization may not assume the move is permanent until it has received confirmation from the member, the member's legal representative or, for incarcerated individuals, public sources (such as a state/federal government entity or other public records).

   The MA organization must initiate disenrollment when it verifies a move is permanent or when the member has been out of the service area (or continuation area, for continuation of enrollment members) for six months from the date the MA organization learned of the change in address. The MA organization must notify the member in writing of the disenrollment. If the member responded and confirmed the permanent move out of the service area, the MA organization must send the notice (Exhibit 36) within 10 calendar days of the member's confirmation that the move is permanent. If the member failed to respond to the request for address confirmation the MA organization must send the notice (Exhibit 35) in the first ten days of the sixth month from the date the MA organization learned of the change in address.

   MA organizations may consider the six months to have begun on the date given by the beneficiary as the date that he/she will be leaving the service area. If the beneficiary did not inform the MA organization of when he/she left the service area, the MA organization can consider the six months to have begun on the date it received information regarding the member's potential change in address (e.g. *D*TRR, out-of-area claims).

   If the member does not respond to the request for verification within the time frame given by the MA organization, the MA organization cannot assume the move is permanent and may not disenroll the member until six months have passed. The MA organization may continue its attempts to verify address information with the member.

3. **Temporary absences** - If the MA organization determines the change in address is temporary, the MA organization may not initiate disenrollment until six months have passed from the date the MA organization received information regarding the member's absence from the service area (or from the date the member states that his/her address changed, if that date is earlier).

   If the MA organization offers a visitor/traveler program, the MA organization must initiate disenrollment if it learns that the individual continues to remain out of the service area during the 12 months (or the length of its visitor/traveler program if less than 12 months).

50.2.1.4 - Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the USPS will return any materials mailed first-class by the organization as undeliverable.

In the event that any member materials are returned as undeliverable, the organization must take the following steps:

1. If the USPS returns mail with a new forwarding address, forward plan materials to the beneficiary and advise the plan member to change his or her address with the Social Security Administration.
2. If the organization receives documented proof of a beneficiary change that is outside of the plan service area or mail is returned without a forwarding address, follow the procedures described in §50.2.1.3.
3. If the organization receives claims for services from providers located outside the plan service area, the organization may choose to follow up with the provider to obtain the member's address.
4. If the organization is successful in locating the beneficiary, advise the beneficiary to update records with the Social Security Administration by:

    a. Calling their toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 7:00 a.m. to 7:00 p.m. EST;
    b. Going to http://www.ssa.gov/changeaddress.html on the SSA website; or
    c. Notifying the local SSA field office. A beneficiary can get addresses and directions to SSA field offices from the Social Security Office Locator which is available on the Internet at: http://www.socialsecurity.gov/locator/.

An organization is expected to continue to mail materials to the member's address of record. If the postal service returns a piece of beneficiary communication to the organization, the plan should document the return and retain the returned material. It should continue to send future correspondence to that same address, as a forwarding address may become available at a later date. Additionally, CMS encourages the MA organization to continue its efforts, as discussed above, to attempt to locate the beneficiary using any available resources, including CMS systems, to identify new address information for the beneficiary. If a forwarding address becomes available, an organization can send materials to that address as in item #1 above.

50.2.1.5 - Notice Requirements

1. **MA organization notified of out-of-area permanent move** - When the organization receives notice of a permanent change in address from the member or the member's legal representative, it must provide notification of disenrollment to the member. This notice to the member, as well as the disenrollment transaction to CMS, must be sent within ten (10) calendar days of the MA organization's learning of the permanent move.

    In the notice, the MA organization is encouraged to inform the member who moves out of the service area that he or she may have certain Medigap enrollment opportunities available to them. These opportunities end 63 days after coverage with the MA organization ends. The MA organization can direct the beneficiary to contact the State Health Insurance Assistance Program (SHIP) for additional information on Medigap insurance.

In the case of incarcerated individuals disenrolled by CMS, we will report the disenrollments to the organization via the daily *D*TRR using a specific TRC. An MA organization must send each affected individual a written notice of the disenrollment within ten (10) calendar days of receipt of the *D*TRR indicating disenrollment due to incarceration.

2. **Out of area for 6 months** - When the member has been out of the service area for 6 months after the date the MA organization learned of the change in address from a source other than the member or the member's legal representative (or the date the member stated that his address changed, if that date is earlier), the MA organization must provide notification of the upcoming disenrollment to the member. Organizations are encouraged to follow up with members and to issue interim notices prior to the expiration of the 6 month period.

   The notice of disenrollment must be provided within the first ten calendar days of the sixth month. The transaction to CMS must be sent within three (3) business days following the disenrollment effective date.

   This notice must also be provided to out-of-area members (as defined in §10) who leave their residence and that absence exceeds six (6) months.

   The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

   EXAMPLE: MA organization receives a *D*TRR on January 20 indicating an "out of area" State and County Code. The 6-month period ends on July 20. The MA organization sends a notice to the member within ten (10) calendar days of receipt of the *D*TRR and does not receive any response from the member indicating this information is incorrect. Therefore, the MA organization will proceed with the disenrollment, effective August 1. The MA organization sends a notice to the member during the first ten (10) calendar days of July notifying him that he will be disenrolled effective August 1. The transaction to CMS must be sent no later than three (3) business days following July 31.

3. **Visitor/Traveler Program Option -** When the member has been out of the service area for 12 months (or the length of its visitor/traveler program if less than 12 months), the MA organization must provide notification of the upcoming disenrollment to the member.

   The notice of disenrollment must be provided during the first ten calendar days of the 12th month (or the length of its visitor/traveler program). The transaction to CMS must be sent within 3 business days following the disenrollment effective date.

   The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

50.2.2 - Loss of Medicare Part A or Part B

With the exception of Medicare Part B-only grandfathered members (as described in §§20.6 and 50.6), the MA organization cannot retain a member in an MA plan if the member is no longer entitled to both

Medicare Part A and Part B benefits. The organization will be notified by CMS that entitlement to either Medicare Part A or Part B has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Medicare Part A or Part B benefits (whichever occurred first).

If a member loses entitlement to Medicare Part A, the MA organization may not allow the member to remain a member of the plan and receive Medicare Part B-only services. In addition, the MA organization may not offer Part A-equivalent benefits and charge a premium for such coverage to members who lose entitlement to Medicare Part A. Likewise, if a member loses entitlement to Medicare Part B at any time, the MA organization may not allow the member to remain in the MA plan.

Notice Requirements - CMS strongly suggests that notices be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 14) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

50.2.3 - Death

The CMS will disenroll a member from an MA organization upon his/her death and CMS will notify the MA organization that the member has died. This disenrollment is effective the first day of the calendar month following the month of death. Organizations may not submit disenrollment transactions to CMS in response to the apparent death of a member. If the eligibility query shows a date of death, the MA organization must submit the enrollment only when the date of death is equal to or greater than the effective date. In anticipation of official notification from CMS via the *D*TRR, organizations may, at their discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices.

Notice Requirements – Following receipt of a CMS notification (via *D*TRR) of disenrollment due to death, CMS strongly suggests that a notice be sent to the member or the estate of the member (see Exhibit 13) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

50.2.4 - Terminations/Nonrenewals

The MA organization must disenroll a member from an MA plan if the MA organization contract is terminated or if the MA organization discontinues offering the plan or reduces its service area to exclude the member.

A member who is disenrolled under these provisions has an SEP, as described in §30.4.3, to elect a different MA plan or Original Medicare. A member who fails to make an enrollment request during this SEP is deemed to have elected Original Medicare.

EXCEPTION

MA organizations can offer an option to continue enrollment in an MA local plan in the organization to members affected by MA plan service area reductions in areas where no other MA plans are

available at that time. If the organization chooses to offer this option, it must notify CMS, and must notify members in the beneficiary non-renewal notification letter.

Members must indicate their desire to take advantage of this option. Members who take this option to continue enrollment become known as "out-of-area members," as defined in §10. The organization may require individuals who choose to continue enrollment in an MA local plan in the organization to agree to receive the full range of basic benefits (excluding emergency and urgently needed care, renal dialysis, and post stabilization) exclusively at facilities designated by the MA organization within the MA local plan service area.

Notice Requirements - The MA organization must give each Medicare member a written notice of the effective date of the termination or service area or continuation area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. Required time frames for these notices are outlined in
42 CFR 422.506 - 422.512.

50.2.5 – Loss of Special Needs Status

A SNP can determine to continue to provide care for an individual that no longer meets the unique eligibility criteria of the plan (i.e., special needs status), if the individual can reasonably be expected to again meet the special needs criteria within a period of time not to exceed six (6) months. For example, a dual eligible individual who loses Medicaid eligibility can be deemed to continue to be eligible for the plan if that individual would likely regain eligibility within six months. The SNP may choose any length of time from one month to six months for deeming continued eligibility, as long as it applies the criteria consistently to all members of the plan and fully informs members of its policy. CMS expects the plan to take into account the ability to meet the needs of an individual that no longer meets special needs status if and when applying the period of deemed continued eligibility. If the member of a SNP does not re-qualify within the plan's period of deemed continued eligibility, the SNP should involuntarily disenroll him or her, with proper notice, at the end of this period. The period of deemed continued eligibility begins the first of the month following the month in which information regarding the loss is available to the organization and communicated to the enrollee, including cases of retroactive Medicaid terminations.

For information on premiums, benefits and cost sharing during the period of deemed continued eligibility, see Chapter 16b of the Medicare Managed Care Manual.
If the SNP is unable to provide continuity of care to a member who loses eligibility, the organization is expected to involuntarily disenroll the member. For example, when a member of an institutional SNP leaves the long-term care facility, he or she should be disenrolled from that SNP if the SNP providers are limited to those within the facility.

Regardless of the date on which the beneficiary loses special needs status, the organization must provide him/her with a minimum of 30 days advance notice of disenrollment.

Refer to Chapters 1 and 16b of the Medicare Managed Care Manual for additional information on Special Needs Plans.

Notice Requirements - The SNP is expected to provide each member a written notice regarding the loss of special needs status within 10 calendar days of learning of the loss of special needs status. This

notice should provide the member an opportunity to prove that he or she is still eligible to be in the plan. In addition, the notice should include information regarding the period of deemed continued eligibility, including its duration, a complete description of the SEP for which such individuals are eligible (see §30.4.4, item #10), the consequences of not regaining special needs status within the period of deemed continued eligibility and the effective disenrollment date (see Exhibit 32). Organizations are encouraged to follow up with members and to issue interim notices prior to the expiration of the period of deemed continued eligibility.

In the event the individual fails to regain special needs status during the period of deemed continued eligibility, the SNP is expected to provide the individual a written notice regarding involuntary disenrollment (see Exhibit 33) and must submit a disenrollment transaction to CMS. The disenrollment notice to the individual and the transaction to CMS should be sent within 3 business days following the last day of the period of deemed continued eligibility; however, in no case should the disenrollment notice to the individual be sent after the transaction is submitted to CMS.

In the event the SNP fails to process disenrollments timely, the organization is expected to take the following action(s):

a. If the SNP has not provided timely notification to the member of the potential for involuntary disenrollment due to loss of special needs status (see Exhibit 32), the SNP should provide this notice to the member and include a proposed disenrollment date that provides the member the full length of the period of deemed continued eligibility. The SNP may not shorten the grace period due its delay in issuing the notice.

b. If the SNP has not provided timely notification to the member of the involuntary disenrollment due to loss of special needs status (see Exhibit 33), the SNP should provide this notice to the member, revise the disenrollment date accordingly and include an explanation of the delay and of the revised disenrollment date.

50.2.6 – Failure to Pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Individuals with Part D-IRMAA must pay this additional premium directly to the government, not to their plans. CMS has established a 3-month initial grace period before individuals in an MA plan with Part D coverage (MA-PD) who fail to pay their assessed Part D-IRMAA will be disenrolled from the MA-PD plan. CMS will report the disenrollments to the organization via the daily *D*TRR using a specific Transaction Reply Code (TRC). The effective date of the disenrollment is the first of the month following the end of the initial grace period.

EXAMPLE: Ms. Jones owes a Part D-IRMAA. CMS bills Ms. Jones her monthly Part D-IRMAA amount in March, April and May. Ms. Jones does not pay all the Part D-IRMAA amounts owed by the due date of the May bill. CMS generates a disenrollment and sends the plan a specific TRC via the daily *D*TRR. The effective date of the disenrollment will be June 1.

An MA organization must send each affected individual a written notice of the disenrollment within ten (10) calendar days of receipt of the *D*TRR indicating disenrollment for non-payment of the Part D-IRMAA.

Notice Requirements - MA organizations are required to notify members of their disenrollment due to failure to pay Part D-IRMAA (see Exhibit 21a.)

When an individual fails to pay both Part D-IRMAA and the plan premium, and the disenrollment effective dates are the same, the TRC for the disenrollment action will reflect the first disenrollment transaction that is processed by MARx. For example, if the plan-generated disenrollment transaction, resulting from the failure to pay plan premiums, is processed by MARx before CMS initiates a disenrollment transaction for failure to pay Part D-IRMAA, the TRC will reflect the plan-generated disenrollment. Thus, plans would issue Exhibit 21 as outlined in Section 50.3 regarding notice requirements.

Similarly, if the CMS-generated disenrollment transaction for failure to pay Part D-IRMAA is processed first, plans will receive the TRC reflecting this action. In such cases, CMS will be unable to process the plan-generated disenrollment transaction (because the individual is already disenrolled); however, plans may review their own billing records to determine if an individual was slated for disenrollment for non-payment of plan premiums. If so, and the effective date of the disenrollment matches the Part D-IRMAA disenrollment effective date, plans have three options for notifying beneficiaries:

1. Plans may send the notice for failure to pay Part D-IRMAA (Exhibit 21a);
2. Plans may send both the notice for failure to pay Part D-IRMAA (Exhibit 21a) and the plan notice for failure to pay premiums (Exhibit 21); or
3. Plans may send the plan notice for failure to pay premiums and include information regarding the Part D-IRMAA disenrollment (Exhibit 21).

Reinstatement for Good Cause – Individuals involuntarily disenrolled from their MA-PD plan for failure to pay Part D-IRMAA have the opportunity to ask CMS for reinstatement into the plan from which they were disenrolled. CMS may reinstate enrollment, without interruption of coverage, if the individual demonstrates good cause and pays **in full** within three (3) calendar months of the disenrollment effective date:

- The Part D-IRMAA amounts that caused the disenrollment for nonpayment of Part D-IRMAA, and
- Any plan premium amounts owed at the time he or she was disenrolled.

For more information on good cause, see §60.3.4.

50.2.7 – Unlawful Presence Status

The MA organization cannot retain a member in a MA plan if the member is not lawfully present in the United States. The organization may not request from a member any documentation of U.S. citizenship or alien status, as CMS provides the official status to the MA organization. CMS will notify the organization (via *D*TRR) that the individual is not lawfully present, and CMS will make the disenrollment effective the first day of the month following the notification by CMS.

Notice Requirements – Following the receipt of a CMS notification (via *D*TRR) of the disenrollment due to unlawful presence, CMS strongly suggests that a notice be provided within ten (10) calendar days of receipt of the *D*TRR (see Exhibit 38) so that the member is aware of the loss of coverage in the plan and any erroneous disenrollments can be corrected as soon as possible. See §60.3.1 for cases of possible erroneous disenrollment or notification.

50.3 - Optional Involuntary Disenrollments

An MA organization may disenroll a member from an MA plan it offers if:

- Premiums are not paid on a timely basis (§50.3.1);
- The member engages in disruptive behavior (§50.3.2); or
- The member provides fraudulent information on an enrollment request, or if the member permits abuse of an enrollment card in the MA plan (§50.3.3).

Notice Requirements - In situations where the MA organization disenrolls the member involuntarily for any of the reasons addressed above, the MA organization must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the MA organization is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and
- Includes an explanation of the member's right to a hearing under the MA organization's grievance procedures.

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

50.3.1 - Failure to Pay Premiums

42 CFR 422.74(d) and Section 504 of the Rehabilitation Act of 1973
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

MA organizations may not disenroll a member who fails to pay MA plan cost sharing under this provision. However, an MA organization has three options when a member fails to pay the MA plan's basic and supplementary premiums. This includes any Part D late enrollment penalty (per Chapter 4 of the Medicare Prescription Drug Benefit Manual).

For each of its MA plans (i.e. each PBP), the MA organization must take action consistently among all members of the discrete plan. For example, an MA organization may have different policies among each of its plans, but it may not have different policies within a plan (other than the optional exception for dual-eligible individuals and individuals who qualify for the Part D low income subsidy, as described below).

The MA organization **may**:

1. Do nothing, (i.e., allow the member to remain enrolled in the same premium plan);

2. Disenroll the member after a grace period and proper notice; or

3. If the member fails to pay the premium for optional supplemental benefits (that is, a package of benefits that the member is not required to accept), but pays the premium for basic and mandatory supplemental benefits, reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefits and retaining the member in the **same** plan

after proper notice. Given these requirements for a downgrade, this option is available only for MA plans that have optional supplemental benefits offered at a higher premium than the basic benefit package. Such an action would be considered an addendum to the member's original request to enroll in the MA plan, and would not be considered a new enrollment request. Refer to Chapter 4 (Benefits and Beneficiary Protections) for a definition of "basic benefit," "mandatory supplement," and "optional supplemental benefits."

If an MA organization chooses to disenroll members for failure to pay premiums, it must apply its disenrollment policy consistently to all members of a plan including applying a consistent grace period of no less than two (2) months. Additionally, the organization must promptly effectuate such disenrollments at the end of the plan's grace period for payment of premiums.

The MA organization may increase the length of the initial grace period or establish a policy of not disenrolling members for failure to pay the plan premium during the calendar year. For example, an MA organization may increase the grace period from 2 months to 6 months to ease the burden for individuals affected by a natural disaster; however, it must provide this extended grace period to everyone in the PBP and not only those in the area affected by the natural disaster. An organization must report any changes to its policy for disenrollment for failure to pay premiums to its CMS account manager before implementing such changes.

If the MA organization chooses to disenroll the member or reduce coverage, the action may only be accomplished after the MA organization has made a reasonable effort to collect the premium and notice has been provided (as described below). If payment has not been received within the grace period, the individual will be disenrolled (or coverage reduced, as applicable).

Organizations **may not** disenroll members for failure to pay premiums (or notify them of impending disenrollment) in cases where the member has requested that premiums be withheld from his/her Social Security benefit check until the organization receives a reply from CMS indicating that the member's request has been rejected. The organization must then notify the member of the premium owed, provide the appropriate grace period, and comply with other applicable requirements prior to disenrolling the member.

Organizations may not involuntarily disenroll individuals who are considered to be in premium withhold status by CMS. Individuals who have requested premium withhold are considered to remain in premium withhold status until either (1) CMS notifies the organization that the premium-withhold request has rejected, failed, or been unsuccessful; or (2) the member requests that he/she be billed directly. Only after one of these actions occurs may a member's status be changed to "direct bill." Once the member is considered to be in "direct bill" status, the organization must notify the member of the premium owed and provide the appropriate grace period, as described below. Organizations must always provide members the opportunity to pay premiums owed before initiating any disenrollment action.

However, even if a member's premium payment status has been changed to "direct bill," if the member can demonstrate that Social Security Administration (SSA) or the Railroad Retirement Board (RRB) has withheld Part C and/or Part D premiums during the coverage month(s) in question, the member will be considered to remain in premium withhold status. Such a member **cannot** be disenrolled for failure to pay his/her premium(s), whether or not the organization actually receives these premiums on a timely basis.

Example 1 – Incorrect Continuation of Premium Withhold: Individual was enrolled in Plan A and selected premium withhold. Individual subsequently enrolls in Plan B and does not select premium withhold. Upon receiving a direct bill from Plan B, the individual provides Plan B with proof that a premium deduction continues from his SSA benefit check. Since the member provided Plan B with evidence that a premium amount is currently being deducted from his check, Plan B cannot initiate the process to disenroll the individual for failure to pay premiums. Plan B must work with CMS to obtain appropriate premium reimbursement.

Further, an individual will continue to be considered in premium withhold status if an organization is notified by CMS that the member's request for premium withholding is not successful as a result of systems/fund transfer issues between CMS and SSA or RRB, or between CMS and the organization. CMS recognizes that in some instances organizations have not received premium amounts in their monthly CMS plan payment for members who have elected SSA or RRB withholding; however, organizations cannot hold their members responsible for such issues, nor penalize them by attempting to disenroll them from their plan. Therefore, the organization **may not** initiate the billing (and subsequent disenrollment process, if necessary) until a member is in "direct bill" status.

Example 2 – Incorrect Data Due to Systems Miscommunication: An individual requests premium withhold, and Plan A correctly submits the request to CMS. The transaction request is submitted successfully by CMS to SSA or RRB and the appropriate premium amount is deducted from the individual's SSA or RRB benefit check. However, due to a systems issue between CMS and SSA or RRB, the premium withhold data is not correctly reflected in CMS systems. Thus, CMS does not pay the correct premium amount to Plan A. Plan A must work with CMS to obtain appropriate premium reimbursement and may not initiate the disenrollment process for the individual for failure to pay premiums while the premium continues to be withheld.

In addition, organizations may not disenroll a member or initiate the disenrollment process if the organization has been notified that the Part D portion of the premium is being paid by a SPAP, or other payer, and the organization has not yet coordinated receipt of the premium payments with the SPAP or other payer (refer to §50.6 of Chapter 14 of the Medicare Prescription Drug Benefit Manual for additional information regarding coordination of premium payments).

While the MA organization may accept partial payments, it has the right to ask for full payment within the grace period. If the member does not pay the required amount within the grace period, the effective date of disenrollment or reduction in coverage is the first day of the month after the period ends. Unless the member elects another MA plan during an applicable election period, any disenrollment processed under these provisions will always result in a change of enrollment request to Original Medicare. **The MA organization has the right to take action to collect the unpaid premiums from the beneficiary at any point during or after this process.**

If a member is disenrolled for failure to pay premiums and attempts to re-enroll in the organization, the MA organization may require the individual to pay any outstanding premiums owed to the MA organization before considering the enrollment request to be "complete."

If the individual is involuntarily disenrolled for failure to pay premiums, in order to re-enroll in that plan, or to enroll in another plan, the individual must request enrollment during a valid period. Payment of past due premiums after the disenrollment date does not create an opportunity for

reinstatement into the plan from which the individual was disenrolled for failure to pay premiums. Likewise, disenrollment for failure to pay premiums does not, in itself, provide the beneficiary an opportunity (SEP) to enroll in a different MA plan.

Calculating the Grace Period

An MA organization must provide plan enrollees with a grace period of not less than 2 calendar months; however, it may provide a grace period that is longer than 2 calendar months, at its discretion (e.g. organizations may elect to provide a 3-month initial grace period to match the Part D-IRMAA initial grace period), provided that similarly situated enrollees are treated equally. The grace period must be a whole number of calendar months and cannot include fractions of months. The grace period cannot begin until the individual has been notified of (billed for) the actual premium amount due, with such notice/bill specifying the due date for that amount and providing an opportunity to pay. For new enrollees of an MA-PD plan, the MA organization must wait until notified by CMS of the actual Part D premium which the beneficiary is responsible for paying directly before the individual can be notified of/billed for the amount due; for these individuals, the due date cannot be until after the organization receives notification from CMS as to the beneficiary's premium and notifies the individual of the amount due. The grace period may begin no earlier than the first of the month for which the premium was unpaid.

NOTE: For individuals who have requested communications in an accessible format, the grace period cannot begin until the organization provides notification (e.g. the bill) in an accessible format.

MA organizations have the following options in calculating and applying the grace period. The organization must apply the same option for all members of a plan.

Option 1 - MA organizations may consider the grace period to end not less than 2 calendar months after the first day of the month for which premium is unpaid.

If the overdue premium and all other premiums that become due during the grace period (in accordance with the terms of the member's agreement with the MA organization) are not paid in full by the end of the grace period, the MA organization may terminate or reduce the member's coverage.

As mentioned previously, the individual must be notified of/billed for the actual premium amount due before the premium can be considered "unpaid." For new enrollees, at a minimum, this cannot occur until CMS notifies the organization of the total premium due from the individual. Upon CMS notification, the organization would notify the individual of the amount due, with a prospective due date.

Under this scenario, MA organizations are encouraged to send subsequent notices as reminders or to show that additional premiums are due. Subsequent notices, therefore, should determine the expiration date of the grace period by reference to this date. Notice requirements are summarized in this section under the heading "notice requirements."

> **EXAMPLE A:** Plan XYZ has a 2-month grace period for premium payment. Plan member Mr. Stone's premium was due on February 1, 2009. He did not pay this premium and on February 7th, the MA organization sent an appropriate notice. Mr. Stone ignores this notice and any subsequent premium bills. The grace period is the months of February and March. If Mr. Stone does not pay his plan premium before the end of March, he will be disenrolled as of April 1, 2009.

EXAMPLE B: Plan QRS has a 3-month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2009. She did not pay this premium and on July 6th, the MA organization sent an appropriate notice. Mrs. Monsoon ignores this notice and subsequent premium bills. The grace period is the months of July, August and September. If Mrs. Monsoon does not pay her owed premiums by the end of this period (September 30), she will be disenrolled effective October 1, 2009.

In short, the MA organization may require that the member pay the overdue premiums in full within the grace period, as well as all other payments becoming due within that period, in order to avoid disenrollment (or a reduction in coverage, where applicable). If the MA organization requires the member to make full payment within the grace period and pay all premiums falling due within that period; however, the MA organization must state so in its initial delinquency notice to the member.

Option 2 - MA organizations may use a "rollover" approach in applying the grace period.

Under this scenario, the grace period would begin on the first of the month for which the premium is unpaid, but if the member makes a premium payment within the grace period, the grace period stops and is revised to reflect the new disenrollment date, depending on the number of months for which premiums are received. The member would then have a new grace period beginning on the 1st day of the next month for which the premium is due. The subsequent notice also would have to be sent within 15 calendar days, as described below, of the next premium due date. This process continues until the member's balance for delinquent premiums is paid in full or until the grace period expires with no premium payments being made, at which time the MA organization may disenroll the member.

Organizations are not required to issue new notices each time the member submits a partial premium payment (i.e. less than one month's premium), since this would not result in a change in the proposed disenrollment date. However, since payment of at least one month's past-due premium causes the disenrollment date to "roll over" (i.e. move forward) commensurate with the number of month's premium received, organizations must issue a notice warning of the potential for involuntary disenrollment (see Exhibit 19) which includes the new disenrollment date whenever payment of at least one month's premium is received during the grace period. These subsequent notices are required to be sent within 15 calendar days of the premium due date that follows receipt of the premium payment.

EXAMPLE

Plan WXY has decided to offer a 2 month grace period for non-payment of plan premiums and has chosen the "rollover" approach to calculating the grace period. A member fails to pay his January premium due January 1. The MA organization sends a notice to the member on January 7th stating that his coverage will be terminated if the outstanding premium is not paid within the grace period. The notice advises him that his termination date would be March 1. The member then pays the January premium, but does not pay the February premium. The grace period is recalculated to begin on the 1st of the next month for which the premium is unpaid (February 1). On February 9th the MA organization sends a notice to the member reflecting the new grace period and the new anticipated termination date of April 1st. The member pays off his balance in full before the grace period expires; therefore, the member's coverage in the MA plan remains intact.

Notice Requirements - If it is the MA organization's policy to disenroll the member or to reduce coverage when a member has not paid premiums, the MA organization must send an appropriate written notice of non-payment of premium to the member **within 15 calendar days** of the premium due date (see Exhibit 19).

The MA organization may send interim notices after the initial notice.

In addition to the notice requirements outlined in §50.3, this notice must:

- Alert the member that the premiums are delinquent;
- Provide the member with an explanation of disenrollment procedures advising the member that failure to pay the premiums within the grace period that began on the 1st of the month for which premium was unpaid will result in termination or reduction of MA coverage, whichever is appropriate according to the MA organization policy, and the proposed effective date of this action;
- Explain whether the MA organization requires full payment within the grace period (including the payment of all premiums falling due during the intervening days, when and as they become due, according to the terms of the membership agreement) in order to avoid termination of membership or reduction in benefits; and,
- Explain the implications of a reduction in coverage (e.g., description of lower level of benefits), if the MA organization policy is to reduce coverage for the nonpayment of optional supplemental benefit premiums.

If a notice is returned to the organization as undeliverable, the organization should immediately implement its procedure for researching a potential change of address (see §§50.2.1.3 and 50.2.1.4) as well. The beneficiary may have moved out of the service area. If the organization confirms the permanent move such that a disenrollment date earlier than the end of the grace period is required, the organization must disenroll the beneficiary for the earlier disenrollment date.

If a member does not pay within the grace period, and the MA organization's policy is to disenroll the member, the MA organization must notify the member in writing providing the effective date of the member's disenrollment (refer to Exhibit 20) and submit a disenrollment transaction to CMS. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the grace period; however, in no case may the disenrollment notice to the individual be sent after the transaction is submitted to CMS. In the event the organization submits a disenrollment request to CMS and later learns that payment was received timely, a reinstatement request must be submitted to CMS (or its designee). In addition, CMS strongly encourages that MA organizations send final confirmation of disenrollment to the member after receiving the *D*TRR (refer to Exhibit 21 for a model letter).

If a member does not pay within the grace period, and the MA organization policy is to reduce coverage by eliminating optional supplemental benefits within the current plan, for the nonpayment of optional supplemental benefit premiums, the MA organization must notify the member in writing no later than 3 business days after the expiration of the grace period that the MA organization is reducing

the coverage and provide the effective date of the change in benefits (refer to Exhibit 22 for a model letter).

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy

MA organizations offering MA-PD plans have the **option** to retain dually eligible members and individuals who qualify for the low income subsidy (LIS) who fail to pay premiums even if the MA organization has a policy to disenroll members for non-payment of premiums. For MA-only plans, organizations may retain individuals who are dually eligible for both Medicare and Medicaid (i.e. individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program).

The MA organization has the discretion to offer this option to dually eligible individuals and individuals who qualify for LIS within each of its MA plans. If the MA organization offers this option in one of its plans, it must apply the policy to all such individuals in that MA plan.

The policy to retain individuals is based upon non-payment of premium for the standard benefit package of the MA plan. If the MA organization chooses this option, any dually eligible individual or individual who qualifies for LIS who fails to pay premiums for any optional supplemental benefit offered would be downgraded to the standard benefit package within that MA plan.

CMS requires that organizations provide members advance notice of plan policy changes. An MA organization will have the discretion as to how it will notify its members of the change, e.g. in an upcoming newsletter or other member mailing, such as the Annual Notice of Change. CMS recommends a general statement in such notifications to avoid confusing other members for whom the policy does not apply.

> **EXAMPLE:** "If you have Medicaid or receive extra help in paying for your Medicare prescription drugs and are having difficulty paying your plan premiums or cost sharing, please contact us."

The plan must document this policy internally and have it available for CMS review.

50.3.2 - Disruptive Behavior

42 CFR 422.74(d)(2)

The MA organization **may** request to disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the MA plan substantially impairs the MA organization's ability to arrange for or provide services to either that particular member or other members of the plan. However, the MA organization may disenroll a member for disruptive behavior only after it has met the requirements of this section and with CMS' approval. The MA organization may not disenroll a member because he/she exercises the option to make treatment decisions with which the MA organization disagrees, including the option of no treatment and/or no diagnostic testing. The MA organization may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the MA organization or any health care professionals associated with the MA organization.

Before requesting CMS' approval of disenrollment for disruptive behavior, the MA organization must make a serious effort to resolve the problems presented by the member. Such efforts must include

providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The MA organization must also inform the individual of his or her right to use the organization's grievance procedures.

The MA organization must submit documentation of the specific case to CMS for review. This includes documentation:

- Of the disruptive behavior;
- Of the MA organization's serious efforts to resolve the problem with the individual;
- Of the MA organization's effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances cited under 42 CFR 422.74(d)(2)(iii) and (iv);
- That the MA organization provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the MA organization then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The MA organization must submit to its CMS Regional Office account manager:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the MA organization's ability to arrange for or provide services to the individual or other members of the MA plan;
- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.

The MA organization may request that CMS consider prohibiting re-enrollment in the MA plan (or plans) offered by the MA organization in the service area.

The MA organization's request for involuntary disenrollment for disruptive behavior must be complete, as described above. The CMS Regional Office will review this documentation and consult with CMS Central Office (CO), including staff with appropriate clinical or medical expertise, and decide whether the organization may involuntarily disenroll the member. Such review will include any

documentation or information provided either by the organization and the member (information provided by the member must be forwarded by the organization to the CMS RO). CMS will make the decision within 20 business days after receipt of all the information required to complete its review. The CMS will notify the MA organization within 5 (five) business days after making its decision.

The Regional Office will obtain Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment, or as provided by CMS. Any disenrollment processed under these provisions will always result in a change of enrollment request to Original Medicare.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the MA organization to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS could require the MA organization to delay the effective date of involuntary disenrollment to coordinate with an MA enrollment request or Part D enrollment period that would permit the individual an opportunity to obtain other coverage. If necessary, CMS will establish an SEP on a case-by-case basis.

Notice Requirements

The disenrollment for disruptive behavior process requires 3 (three) written notices:

1. Advance notice to inform the member that the consequences of continued disruptive behavior will be disenrollment;

2. Notice of intent to request CMS' permission to disenroll the member; and

3. A planned action notice advising that CMS has approved the MA organization's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the MA organization must provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the MA organization's ability to arrange for or provide services to the member or to other members of the MA plan. The notice must explain that his/her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The MA organization must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the MA organization must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the MA organization's efforts, then the MA organization must notify him/her of its intent to request CMS' permission to disenroll him/her for disruptive behavior. This notice must also advise the member of his/her right to use the organization's grievance procedures and to submit any information or explanation. Refer to Chapter 13, "Grievances, Organizations Determinations, and Appeals," for the appropriate procedures for grievances. The MA

organization must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS.

Planned Action Notice

If CMS permits an MA organization to disenroll a member for disruptive behavior, the MA organization must provide the member with a written notice that, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. The MA organization may only provide the member with this required notice after CMS notifies the MA organization of its approval of the request.

The MA organization can only submit the disenrollment transaction to CMS after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the MA organization gives the member a written notice of the disenrollment, or as provided by CMS.

50.3.3 - Fraud and Abuse

42 CFR 422.74(e)(1)

An MA organization **may** request to cancel the enrollment of a member who knowingly provides, on the enrollment request form or by another enrollment request mechanism, fraudulent information that materially affects the determination of an individual's eligibility to enroll in the plan. The organization may also request to disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider. Such a disenrollment is effective the first day of the calendar month after the month in which the organization gives the member the written notice.

When such a cancellation or disenrollment occurs, the organization must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse. Any disenrollment processed under these provisions will always result in a change of enrollment to Original Medicare.

Notice Requirements - The MA organization must give the member a written notice of the disenrollment that contains the information required at §50.3.

50.4 - Processing Disenrollments

50.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from a member, the MA organization is responsible for submitting the disenrollment transaction to CMS in a timely, accurate fashion. Such transmissions must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The MA organization must maintain a system for receiving, controlling, and processing voluntary disenrollments from the MA organization. This system should include:

- Dating each disenrollment request as of the date it is received (regardless of whether the request is complete at the time it is received by the MA organization) to establish the date of receipt;
- Dating supporting documents for disenrollment requests as of the date they are received;
- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;
- Transmitting disenrollment information to CMS within 7 calendar days of the receipt of the completed disenrollment request from the individual or the employer or union (whichever applies). If the disenrollment information is received through the employer or union, the MA organization must obtain the member's written disenrollment request from the employer or union;
- For disenrollment requests received by the MA organization, notifying the member in writing within ten calendar days after receiving the member's written request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see Exhibit 11 for a model letter). MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the *D*TRR;
- For all other voluntary disenrollments (i.e., voluntary disenrollments made by the beneficiary through 1-800-MEDICARE, by enrolling in another MA plan or PDP or by consenting to passive enrollment into a Medicare-Medicaid demonstration plan, which the MA organization would not learn of until receiving the *D*TRR), notifying the member in writing to confirm the effective date of disenrollment within ten calendar days of the availability of the TRR (see Exhibits 12 and 12c for model letters). This notice requirement does not apply to a disenrollment resulting from a member switching from one benefit package to another within the same organization (i.e., a PBP change), unless enrollment in the new PBP is the result of passive enrollment into a Medicare-Medicaid demonstration plan.

50.4.2 – When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the MA organization must document all efforts to obtain additional documentation to complete the disenrollment request and have an audit trail to document why additional documentation was needed before the request could be considered complete. The organization must make this determination, and within 10 calendar days of receipt of the disenrollment request, must notify the individual that additional information is needed.

If a written disenrollment request is submitted and the signature is not included, the MA organization may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

For AEP disenrollment requests, additional documentation to make the request complete must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the disenrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

50.4.3 - Involuntary Disenrollments

The MA organization is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The MA organization must maintain a system for controlling and processing involuntary disenrollments from the MA organization. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and
- For all involuntary disenrollments except disenrollments due to death and loss of Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights.

In addition, CMS strongly encourages MA organizations to send confirmation of involuntary disenrollment to ensure the member discontinues use of MA organization services after the disenrollment date.

50.5 - Disenrollments Not Legally Valid

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §60.3 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §50.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in §10, is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

The CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her legal representative did not intend to disenroll from the MA organization. If there is evidence that the member did not intend to disenroll from the MA organization, the MA organization should submit a reinstatement request to CMS (or its designee). Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or
- Request by the member for cancellation of disenrollment before the effective date (refer to §60.2 for procedures for processing cancellations).

Discontinuation of payment of premiums alone does not necessarily indicate that the member has made an informed decision to disenroll.

In contrast, CMS believes that a member's deliberate attempt to disenroll from a plan (e.g. sending a written request for disenrollment to the MA organization, or calling 1-800-MEDICARE) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

50.6 - Disenrollment of Grandfathered Members

As discussed in §20.6, any individual who was enrolled in a §1876 risk plan effective December 1, 1998, or earlier, and remained enrolled with the risk plan on December 31, 1998, automatically continued to be enrolled in the MA organization on January 1, 1999, even if he/she was not entitled to Medicare Part A or did not live in an MA plan service area or MA organization continuation area.

Disenrollment procedures for grandfathered members are generally the same as those for other members. The MA organization must disenroll any grandfathered member if:

- The member dies;
- The member loses either Medicare Part A or Part B (or for Part B only members, enrollment in Medicare Part B ends for the member);
- The member permanently moves into the continuation area, but does not choose to continue enrollment or moves to an area that is out of the service or continuation area;
- The member permanently moves out of the vicinity, making continued enrollment no longer reasonable. For example, a move of only a short distance may not affect the member's ability to continue to access the plan; therefore, continued enrollment would be reasonable; or,
- The MA organization contract is terminated or the service area or continuation area is reduced with respect to all MA individuals who live in the area where the individual resides.

  NOTE: The member may be offered the option to continue enrollment, as described in §50.2.4.

50.7 - Disenrollment Procedures for Employer/Union Sponsored Coverage Terminations

When the contract between an employer or union group and an MA organization is terminated, or the employer/union determines that a beneficiary is no longer eligible to participate in the employer/union sponsored MA plan[2], the MA organization has the option to follow one of two procedures to disenroll beneficiaries from the current employer/union sponsored MA plan in which the individual is enrolled:

[2] The employer/union establishes criteria for its retirees to participate in the employer/union sponsored MA plan. These criteria are exclusive of and in addition to the eligibility criteria for MA enrollment. Eligibility criteria to participate and

For both of the following options, the MA organization must ensure that the employer or union agrees to the following:

- The employer or union will provide the MA organization with timely notice of contract termination or the ineligibility of an individual to participate in the employer or union group sponsored MA plan. Such notice must be prospective, not retroactive.

- The employer or union must provide a prospective notice to its members alerting them of the termination event and of other insurance options that may be available to them through their employer or union.

Option 1: Enroll the individual(s) in another MA plan (i.e. individual plan) offered by the same MA organization unless the beneficiary makes another choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area. The individual plan selected for this option must be the same type of plan. For example, if the employer/union sponsored plan was an MA-PD coordinated care plan, the individual plan in this option must be an MA-PD coordinated care plan.

- Beneficiaries may elect another MA plan offered by the employer or union, join Original Medicare or join another MA plan as an individual member instead of electing the individual MA plan offered by the same MA organization.

    - If the beneficiary prefers not to be enrolled in the individual plan, he/she may contact the MA organization.
    - If the beneficiary would prefer enrolling in a different MA plan as an individual member, he/she must submit an enrollment request to his/her newly chosen MA organization.

- If the individual takes no other action, he/she will become a member of the individual plan offered by the same MA organization that offered the employer/union sponsored plan.

- **MA Notice requirements** - The MA organization (or the employer or union, acting on its behalf) must provide <u>prospective</u> notice to the beneficiary that his/her plan is changing, including information about benefits, premiums, and/or copayments, at least 21 calendar days prior to the effective date of enrollment in the individual plan.

Option 2: Disenroll individual(s) from the employer/union sponsored MA plan to Original Medicare following prospective notice.

- **MA Notice requirements -** The MA organization (or the employer or union, acting on its behalf) must provide prospective notice to the beneficiary that his/her plan enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the beneficiary may choose and how to request enrollment.

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receive employer/union sponsored benefits may include spouse/family status, payment to the employer/union of the individual's part of the premium, or other criteria determined by the employer/union.

- If the employer/union sponsored plan was an MA-PD plan, the individual must be advised that the disenrollment action means the individual will not have Medicare drug coverage. Notice must include information about the potential for late-enrollment penalties that may apply in the future.

The MA organization must outline in its written policies and procedures the option(s) it follows and must apply the same option for all members of a particular employer/union sponsored plan. It is the MA organization's responsibility to ensure that the required elements of the disenrollment procedures described above are understood by the employer or union and are part of the agreement with each employer or union, including contract termination notification requirements.

50.8 - Disenrollment Procedures for Medicare MSA Plans

Members of Medicare MSA plans may only disenroll in writing through the MA organization offering the Medicare MSA plan; they may not disenroll through 1-800-MEDICARE. Election periods and effective dates for disenrollment from Medicare MSA plans are outlined in §30.7.

MA organizations offering Medicare MSA plans must otherwise follow the disenrollment policies and procedures outlined in §§50.2 through 50.5.

60 - Post-Enrollment Activities

42 CFR *422*.60 & 422.66

Post-enrollment activities begin after the MA organization receives the enrollment request from the individual (e.g., cancellations) and last until a decision is made with respect to an individual's enrollment request (e.g., retroactive transactions).

60.1 - Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment request for the same individual with the same effective date in the same reporting period. An individual may generally not be enrolled in more than one MA, cost, HCPP or PDP plan at any given time (however, an individual may be simultaneously enrolled in a cost plan and a separate PDP plan or in certain MA plan types and a separate PDP plan).

Generally, the last enrollment request the beneficiary makes during an enrollment period will be accepted as the plan into which the individual intends to enroll. If an individual elects more than one plan for the same effective date and with the same application date, the first transaction successfully processed by CMS will take effect. Because simultaneous enrollment in certain MA plan types and a separate PDP is permitted, CMS systems will accept both enrollments.

Generally, given the use of the application date to determine the intended enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because the enrollment requests have the same application date.

EXAMPLES

- Two MA organizations receive enrollment forms from one individual. MAO #1 receives a form on March 4th and MAO #2 receives a form on March 10. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in MAO #2 will be the transaction that is accepted and will be effective on April 1 because the application date on the enrollment transaction is the later of the 2 submitted. Both plans receive the appropriate reply on the *D*TRR.

- Two MA organizations (MAOs) receive enrollment requests from one individual for an April 1 effective date. MAO #1 receives a paper enrollment form with all required information on March 5th. The beneficiary completed an enrollment request for MAO #2 by telephone on the same day, March 5th. Both enrollment requests have the same application date, since they were received by the MAO on the same date. Both enrollments were submitted to CMS prior to the April cut-off date. MAO #1 transmitted the enrollment to CMS on March 5th, the day it received the enrollment request; however, MAO #2 waited until March 8th to transmit the enrollment to CMS. The enrollment for MAO #1 will be the transaction that is effective on April 1, as it was the first transaction successfully processed by CMS.

In the event a rejection for a multiple transaction is reported to the MA organization, the organization may contact the individual. If the individual wishes to enroll in a plan offered by the organization that received the multiple transaction reject, s/he must submit a new enrollment request during a valid enrollment period.

60.2 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Unless otherwise directed by CMS, an individual may cancel his/her enrollment (or disenrollment) request only by contacting the organization prior to the effective date of the enrollment (or disenrollment). For enrollments into employer or union sponsored plans, cancellations received by the employer or union prior to the enrollment effective date are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary. Refer to §§60.3 and 60.5.

If a beneficiary verbally requests a cancellation, the MA organization should document the request. MA organizations have the right to request that a cancellation be in writing. However, they may not delay processing of a cancellation until the request is made in writing if they have already received a verbal cancellation request from the beneficiary.

For facilitated enrollment as described in §40.1.5 of this chapter, a beneficiary may cancel the enrollment and affirmatively decline Part D benefits by telephone. The MA organization may not require these cancellations in writing.

60.2.1 - Cancellation of Enrollment

An individual's enrollment request can be cancelled only if the cancellation request is received by the organization prior to the effective date of the enrollment via phone, in writing or in person, unless otherwise directed by CMS.

To ensure the cancellation is honored, the MA organization should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment by the time it receives the valid request for cancellation, it must submit a cancellation transaction to CMS to cancel the now-void enrollment transaction. In the event the cancellation transaction fails or the MA organization has other difficulty, the MA organization must submit the request to cancel the action to the CMS Retroactive Processing Contractor in order to cancel the enrollment.

When canceling an enrollment transaction, the MA organization must send a letter to the individual that states that the cancellation is being processed (see Exhibit 25). This notice should be sent within ten calendar days of receipt of the cancellation request. This notice must inform the member that the cancellation should result in the individual remaining enrolled in the health plan in which he/she was originally enrolled, so long as the individual remains eligible to be enrolled in that health plan.

An MA organization may submit a transaction to cancel only those enrollment transactions it submitted. To cancel an enrollment, the MA organization must submit an enrollment cancellation transaction (transaction code 80) with an effective date equal to the effective date of the enrollment being cancelled.

If the member's request for cancellation occurs after the effective date of the enrollment, the cancellation generally cannot be processed. (An exception to this is a cancellation requested during the Outbound Education and Verification (OEV) process.) The organization must inform the beneficiary

that he/she is a member of its MA plan. If he/she wants to return to the other MA plan he/she will have to submit an enrollment request during a valid election period for a prospective enrollment effective date.

If the member wants to return to Original Medicare instead of returning to his/her previous plan, the member must be instructed to disenroll from the previous plan as described in §50.1 of this chapter. The member must be informed that the disenrollment must be made during an election period (described in §30.5) and will have a current effective date (as prescribed in §30.5), and must be instructed to continue to use plan services until the disenrollment goes into effect.

Regardless of the plan personnel receiving the request, the plan must document all contact with the beneficiary associated with the cancellation request.

When an organization receives notification of an individual's reinstatement, the organization has ten (10) calendar days to send the individual a notice of reinstatement (Exhibit 25a).

CANCELLATION OF MEDICARE MSA ENROLLMENT REQUEST:

An individual who elects a Medicare MSA plan during an AEP, and who has never before enrolled in a Medicare MSA plan, may revoke (i.e., "cancel") that enrollment request, preferably by December 7 (but law allows beneficiaries to do so by December 15) of the year in which s/he requested enrollment in the Medicare MSA plan. This cancellation will ensure the enrollment request does not go into effect on January 1. After December 7 and up to December 15, the beneficiary may only return to Original Medicare and cannot enroll into another MA plan or into a stand-alone PDP.

60.2.2 - Cancellation of Disenrollment

A member's disenrollment can be canceled only if the request is made prior to the effective date of the disenrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the MA organization should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it must submit a cancellation of disenrollment transaction, transaction code 81, to CMS to cancel the now-void disenrollment transaction. In the event the MA organization has submitted the disenrollment and is unable to submit the transaction code 81, or has other difficulty, the organization should submit the request to cancel the action to the CMS Retroactive Processing Contractor in order to cancel the disenrollment.

An MA organization may submit a transaction to cancel only those disenrollment transactions it submitted. To submit an action to cancel a disenrollment, the MA organization must submit a transaction code 81 (cancellation of disenrollment), with the effective date equal to the effective date of the disenrollment being cancelled.

The MA organization must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using MA plan services (see Exhibit 26). This notice should be sent within ten calendar days of receipt of the cancellation request.

Within ten (10) calendar days of receipt of confirmation of the individual's reinstatement, the organization must send the member written notification of the reinstatement (Exhibit 25a).

If the member's request for cancellation occurs after the effective date of the disenrollment, the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §60.3.2. If a reinstatement will not be allowed, the MA organization should instruct the member to submit a new enrollment request during a valid election period (described in §30), and with a current effective date, as prescribed in §30.5.

60.2.3 – When A Cancellation Transaction is Rejected by CMS Systems (Transaction Reply Code (TRC) 284)

When an MA organization receives a TRC 284 (Cancellation Rejected), while the cancellation remains valid, it could not be processed automatically in CMS' systems. The MA organization must investigate the circumstances behind the rejection. If the rejection was due to incorrect data on the transaction, the MA organization must correct the data and resubmit it to CMS. If the rejection was not due to such an error, and the request to cancel is valid, the MA organization must promptly submit the request to CMS (or its designee) for resolution.

60.2.4 – Cancellation Due to Notification from CMS (TRC 015)

When an MA organization receives a TRC 015 (Enrollment Cancelled), it indicates that an enrollment must be cancelled. A cancellation may be the result of an action on the part of the beneficiary, CMS or another plan.

Within ten (10) days of receiving the TRC 015, the plan must send the individual an acknowledgment notice of the cancellation (Exhibit 25b).

60.3 - Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §50.5 to determine whether a disenrollment is not legally valid) or if the circumstances justify a reinstatement. The most common reasons warranting reinstatements are:

1. Disenrollment due to erroneous death indicator;
2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator;
3. Disenrollment due to erroneous incarceration or unlawful presence information;
4. Reinstatements Based on Beneficiary Cancellation of New Enrollment;
5. Plan error;
6. Demonstration of good cause for failure to pay plan premiums or Part D-IRMAA timely.

When a disenrolled individual contacts the MA organization to state that he or she was disenrolled due to item 1 (erroneous death indicator), item 2 (erroneous loss of Medicare Part A or Part B indicator) or item 5 (plan error), and states that he or she wants to remain a member of the MA plan, the MA

organization must instruct the member in writing to continue to use MA plan services (refer to Exhibits 15, 16 and 17). The MA organization must send the notice within ten (10) calendar days of the individual's contact with the organization to report the erroneous disenrollment. Accordingly, plan systems should indicate active membership as of the date the organization instructs the individual to continue to use plan services.

When a disenrolled individual contacts the MA organization about either item 3 (erroneous incarceration or unlawful presence information), item 4 (reinstatement based on enrollment cancellation of new enrollment) or item 6 (good cause), plans should follow the guidance outlined below pertaining to those unique situations.

A reinstatement is viewed as a correction necessary to "erase" an invalid disenrollment action, and, as such, does not require an election period. Therefore, reinstatements may be made back to a date when an MA plan was closed for enrollment. Payment alone of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums.

CMS (or its designee) will review requests for reinstatements on a case-by-case basis.

Within ten (10) calendar days of receipt of *D*TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

60.3.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator, or Erroneous Loss of Medicare Part A or Part B, Erroneous Incarceration Information, or Erroneous Unlawful Presence Information

A member must be reinstated if he or she was disenrolled in error, since the individual continues to be eligible. This may occur in the following situations:

- Erroneous death indicator;
- Erroneous loss of Part A or Part B;
- Erroneous lawful presence status; or
- Erroneous incarceration information.

As outlined in 42 CFR 422.74(c), MA organizations have the option of sending notification of disenrollment due to:

- Death;
- Loss of Part A or Part B entitlement; or
- Unlawful presence in the U.S.

The CMS strongly suggests that MA organizations send these notices in these three situations, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibits 13, 14 and 38 for model letters.

If CMS involuntarily disenrolls an individual due to incarceration, a notice is required because the individual resides out of the plan's service area. See §50.2.1.5 for notice requirements for disenrollment due to incarceration. Refer to Exhibit 37.

Erroneous disenrollments must be corrected and the corresponding reinstatements processed, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of MA eligibility.

Reinstatements for erroneous death indicator or loss of Part A or Part B entitlement:
Individuals can dispute the disenrollment due to death indicator or loss of Part A or Part B entitlement. In such cases, the MA organization is expected to acknowledge the individual's request for reinstatement and direct him or her to continue to use the MA plan services while the issue is resolved with the Social Security Administration (SSA). Organizations may request that such individuals provide evidence of MA eligibility by a particular date; however, should the individual provide evidence after that date, the error must still be corrected by the MA organization.

To request consideration for reinstatement following disenrollment due to erroneous death indicator, erroneous loss of Medicare Part A or Part B, the MA organization must submit to CMS (or its designee) a copy of the letter to the member informing him or her to continue to use MA plan services until the issue is resolved. The organization must indicate the date the letter was sent. Refer to model letters in Exhibits 15and 16. Within ten (10) calendar days of receipt of *D*TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

CMS will attempt to automatically reinstate individuals that were auto-disenrolled by a report of date of death if there is a subsequent date of death correction that impacts the plan enrollment.

Reinstatements for erroneous incarceration or unlawful presence status information:
Individuals alleging disenrollment due to erroneous incarceration information or erroneous unlawful presence status must have their complaints reviewed by the MA organization and possibly referred to SSA. MA organizations are not required to provide coverage to such individuals while the issue is reviewed by the plan or SSA.

For individuals who contest their disenrollment on these bases, the MA organization should check CMS' systems to see if the incarceration or unlawful presence status has been removed (via audit notification in MARx) and that the person is otherwise eligible to remain enrolled as of the disenrollment effective date. If the individual is otherwise eligible for enrollment, the reinstatement request may be sent to the CMS Retroactive Processing Contractor (RPC) instead of referring the individual to SSA. However, if CMS systems continue to reflect an incarcerated or unlawful presence status, the plan should refer the beneficiary to SSA so that they may review their records and make corrections, as appropriate. If the information or status is determined to be erroneous by SSA, CMS' systems will be updated. The plan may check CMS systems to see if the incarceration or unlawful presence status has been removed, and, if the person is otherwise eligible to remain enrolled, may send the reinstatement request to the CMS RPC. The MA organization will receive notification of the

individual's reinstatement from CMS or via the TRR. At that time, services should resume and coverage should be seamless, as though the individual was never disenrolled. CMS suggests that the organization send the member notification of the reinstatement (Exhibit 25a) within ten (10) days of receipt of *D*TRR confirmation of the individual's reinstatement.

60.3.2 - Reinstatements Based on Beneficiary Cancellation of New Enrollment

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who were automatically disenrolled because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before the effective date.

In this situation, that is, if an individual has since changed his/her mind and wants to remain enrolled in the previous plan, the individual must cancel the enrollment into the new plan, as described in section 60.2.1. When a cancellation of enrollment in a new plan is properly made, the associated automatic disenrollment from the previous MA plan becomes invalid. Upon successful cancellation of enrollment in the new plan, CMS systems will attempt to automatically reinstate enrollment in the previous plan. Because this process is automatic, it is generally not necessary to request reinstatement via the Regional Office or Retroactive Processing Contractor. Within ten (10) days of receipt of *D*TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

In cases where the valid cancellation request is not processed timely or CMS systems cannot complete the request, the new plan must submit a request to the Retroactive Processing Contractor to cancel the enrollment. This request will require complete documentation, including evidence that the beneficiary requested cancellation of enrollment in the new plan within required timeframes.

If the previous plan becomes aware of an unsuccessful reinstatement, the previous plan may contact a CMS Account Manager to investigate the issue with the new plan.

If the disenrolled individual contacts the previous plan requesting to remain a member of that plan, the MA organization should inform the individual that reinstatement of enrollment is an option only if the individual successfully cancels enrollment in the "new" plan; accordingly, the organization should refer the individual to the "new" plan to inquire about his or her options.

60.3.3 - Reinstatements Due to Mistaken Disenrollment Due to Plan Error

A disenrollment that is not the result of either a valid voluntary request or a valid circumstance that requires involuntary disenrollment is erroneous. When an erroneous disenrollment is the result of plan error, the plan must reinstate the individuals who were disenrolled.

In the case of an erroneous disenrollment by the organization that is a result of an error the part of the organization, the organization must restore the enrollment in its records. Additionally, the organization must cancel the disenrollment action from CMS's records, if the organization had previously submitted such a transaction to CMS. Organizations must use the disenrollment cancellation function to complete this action for effective dates within the parameters that CMS systems allow for such corrections. For effective dates outside these parameters, the organization must process the request

according to the guidance for processing retroactive enrollment and disenrollment requests including full documentation and explanation as required.

Within ten (10) days of receipt of *D*TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

60.3.4 - Reinstatements Based on a Determination of Good Cause for Failure to Pay Plan Premiums or Part D-IRMAA Timely

If an individual has been involuntarily disenrolled for failure to pay either plan premiums (under §50.3.1) or Part D-IRMAA (under §50.2.6), he or she may request reinstatement no later than 60 calendar days following the effective date of disenrollment. Reinstatement for good cause, pursuant to 42 CFR 422.74(d)(1)(v), will occur only when:

1. The individual requests reinstatement within 60 days of disenrollment effective date;
2. The individual has been determined to meet the criteria specified below (i.e., receives a favorable determination); and
3. (a) Within three (3) months of disenrollment for nonpayment of plan premiums, the individual pays **in full** the plan premiums owed at the time he or she was disenrolled or (b) Within three (3) months of disenrollment for nonpayment of Part D-IRMAA, the individual pays **in full** the Part D-IRMAA and any plan premiums owed at the time he or she was disenrolled.

Criteria for Reinstatement: Reinstatement of enrollment for good cause is provided only in rare circumstances in which the member or his or her authorized representative (i.e. the individual responsible for the member's financial affairs) was unable to make timely payment due to circumstances over which they had no control and they could not reasonably have been expected to foresee. Requests for reinstatement must be accompanied by a credible statement (verbal or written) explaining the unforeseen and uncontrollable circumstances causing the failure to make timely payment. An individual may make only one reinstatement request for good cause in the 60-day period.

Generally, these circumstances constitute good cause:

- A serious illness, institutionalization and/or hospitalization of the member or his or her authorized representative (i.e. the individual responsible for the member's financial affairs), that lasted for a significant portion of the grace period for plan premium or Part D-IRMAA payment;
- Prolonged illness that is not chronic in nature, a serious (unexpected) complication to a chronic condition or rapid deterioration of the health of the member, a spouse, another person living in the same household, person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs) that occurs during the grace period for the plan premium or Part D-IRMAA payment;
- Recent death of a spouse, immediate family member, person living in the same household or person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs); or
- Home was severely damaged by a fire, natural disaster or other unexpected event, such that the member or the member's authorized representative was prevented from making arrangement for payment during the grace period for plan premium or Part D-IRMAA;

- An extreme weather-related, public safety or other unforeseen event declared as a Federal or state level of emergency prevented premium payment at any point during the plan premium or Part D-IRMAA grace period. For example, the member's bank or U.S. Post Office closes for a significant portion of the grace period; or
- For disenrollments effectuated by CMS for failure to pay Part D-IRMAA, Federal government error (i.e., CMS, SSA or RRB) caused the payment to be incorrect or late, and the member was unaware of the error or unable to take action prior to the disenrollment effective date.

There may be situations in addition to those listed above that result in favorable good cause determinations. If an individual presents a circumstance which is not captured in the listed examples, it must meet the regulatory standards of being outside of the member's control or unexpected such that the member could not have reasonably foreseen its occurrence, and this circumstance must be the cause for the non-payment of plan premiums or Part D-IRMAA. CMS expects non-listed circumstances will be rare.

Examples of circumstances that do not constitute good cause include:

- Allegation that bills or warning notices were not received due to unreported change of address, out of town for vacation, visiting out of town family, etc.;
- Authorized representative did not pay timely on member's behalf;
- Lack of understanding of the ramifications of not paying plan premiums or Part D-IRMAA;
- Could not afford to pay premiums during the grace period; or
- Need for prescription medicines or other plan services.

For examples of cases for favorable and unfavorable good cause determinations, see Appendix 4.

For the purpose of determining good cause for members with authorized representatives, the criteria for both favorable and unfavorable determinations apply as though the authorized representative is the member.

The inability to afford premiums or failure to make timely payment by a member or an authorized representative alone is not grounds for a favorable good cause determination and reinstatement. In addition, good cause determinations are not organization determinations related to coverage and, therefore, are not appealable. (See 42 CFR 422, subpart M.) An individual may not make more than one reinstatement request for good cause in the same 60-day period following disenrollment, including instances in which the initial request resulted in an unfavorable determination. However, an individual has the right to file a grievance against the plan related to the involuntary disenrollment.

An individual who has been disenrolled for failure to pay plan premium, regardless of whether he or she has also been assessed Part D-IRMAA, remains disenrolled from the plan and does not have access to plan coverage of services until he or she receives a favorable good cause determination and the plan receives full payment of the plan premium amounts owed at the time he or she was disenrolled.

An individual who has been disenrolled by CMS for failure to pay Part D-IRMAA remains disenrolled from the plan and does not have access to plan coverage of services until the reinstatement occurs and is reported to the plan on the *D*TRR or the plan is contacted by the CMS caseworker after he or she has successfully updated the member's enrollment record in MARx. Once a reinstatement occurs, the

individual's disenrollment will be cancelled and his or her coverage will be continuous, assuming the individual continues to be eligible for enrollment in that plan.

60.3.4.1 - Process for Good Cause Determinations for Nonpayment of Plan Premiums

Pursuant to 42 CFR 422.74(d), CMS has assigned the handling of good cause determinations to plans.

When a disenrolled individual initially contacts the MA organization following disenrollment for failure to pay plan premiums and indicates that he or she "has a good reason for not having paid the premiums", the MA organization must:

- Confirm that the request for reinstatement is being made within 60 calendar days of the disenrollment effective date;
- Inform the individual that reinstatement is a possibility only if it is determined that his or her failure to make timely payment was due to circumstances over which he or she had no control and could not reasonably have been expected to foresee;
- Obtain a credible statement from the individual regarding the circumstance that prevented him or her from making timely payment; and
- Obtain affirmation from the individual indicating his or her willingness and ability to pay all overdue plan premiums within three (3) months of the disenrollment date in order for reinstatement to occur.

If all of these preliminary requirements are not met, the individual is not eligible to be considered for reinstatement for good cause. An individual may not make more than one reinstatement request for good cause during the same 60-day period. For example, an individual requesting reinstatement indicates that he had no unusual or unexpected circumstance that caused the nonpayment of premiums and the plan determines that he does not qualify for his case to be reviewed under good cause. The plan is expected to clearly communicate that the individual's request will not be reviewed because the situation does not meet the criteria (e.g., not unusual or unexpected). The individual remains disenrolled and may not make another request for good cause during the same 60-day period following the involuntary disenrollment.

If all of the above criteria are met, the plan will review the request and will make a favorable or unfavorable good cause determination. CMS expects that plans make such determinations within five (5) business days of initial receipt of the request, so that the individual has a reasonable amount of time to make full payment for reinstatement. For requests received by mail, the initial request is considered received by the plan at the time it arrives in the organization's mailbox or mailroom. For requests received by fax, the initial request is considered received by the plan at the time when the fax is received on the organization's fax machine. For requests received by telephone, the initial request is considered received by the plan at the time the organization's representative receives the incoming call.

There is no additional time allotted for plans to gather information not collected at the point of initial contact. Plans would need to collect any additional data they feel is needed to make a determination and make that determination within five (5) business days of the date on which the individual first contacts the plan. In such cases where the plan does not have sufficient information to determine if the member's circumstances meet the requirements, it should make a good faith effort to collect it within that timeframe (e.g., making multiple attempts on different days or at different times). However, if

attempts are unsuccessful, the plan must use the information provided with the initial request to make its determination.

If the plan makes a favorable determination and there are amounts owed to the plan for past due premiums, the plan should notify the individual of this decision within three (3) business days of making the determination. If the plan offers immediate payment options, such as payment by credit card via phone, it may provide the notification verbally; however, if the individual does not complete the payment at that time, the plan should issue a written notice to ensure that the individual has the information necessary to pay the owed amounts. This notice will specify the amount owed (i.e., the premiums owed at the time of disenrollment), the date by which payment must be received for reinstatement (i.e., last day of the third month following the disenrollment effective date), where to send payment, and/or other payment options such as credit card or direct withdrawal from a bank account, if offered by the plan. (See Exhibit 22b).

If, at the time the plan makes a favorable determination, there are no amounts owed to the plan for past due premiums, the plan should notify the individual of this decision either verbally or in writing within three (3) business days of making the determination. Exhibit 22e is a model notice for the scenario in which an individual receives a favorable good cause determination and has already paid the amount required for reinstatement. If verbal notification is attempted but unsuccessful, a written notice should be provided. Verbal notification must be documented by the plan to meet CMS' retroactive processing contractor reinstatement submission requirements.

If the plan makes an unfavorable determination, the plan should notify the individual of this decision by phone or in writing within three (3) business days of making the determination.

If an individual has received a favorable good cause determination, reinstatement in CMS systems may not occur until and unless all required payments are made within three (3) months of the disenrollment effective date. If the individual pays all the owed amounts prior to the three-month deadline, the plan should resume coverage at that time and submit the reinstatement request to the CMS Retroactive Processing Contractor.

Plans have additional time beyond the deadline (i.e., three (3) months from the disenrollment effective date) to verify payment by the bank and credit the payment to the member's account with the plan. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five (5) calendar days beyond the payment deadline to process the payment and submit the reinstatement request to the CMS Retroactive Processing Contractor..

Reinstatements for good cause are considered complete by CMS when TRC 287 (Enrollment Reinstated) is sent by CMS to the plan.

Within ten (10) calendar days of receipt of *D*TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a). In an effort to prevent members from falling behind in premium payments in the future, plans are encouraged to educate them on any automated payment mechanisms their plan offers, as well as the availability of selecting automatic premium withhold through their SSA or RRB benefits.

An individual may not be reinstated in cases where:

- the individual pays all plan premiums owed, but does not receive a favorable good cause determination; or
- the individual receives a favorable good cause determination, but does not pay the plan premiums owed within three (3) months of the disenrollment effective date.

In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request only if he or she has a valid election period (i.e., AEP, SEP, etc.), following enrollment procedures outlined in Sections 30 and 40.

Example A: Mr. Smith is disenrolled for failure to pay plan premiums on April 1. Mr. Smith contacts the plan and makes his request for reinstatement on April 15 and receives a favorable good cause determination on April 23. The plan notifies Mr. Smith of the amount he owes by June 30 in order to be reinstated into the plan. Mr. Smith pays the amount due on June 15. Mr. Smith is reinstated into the plan. (Note: If Mr. Smith did not pay his owed amount by June 30, he would not be reinstated.)

Example B: Mr. Smith is disenrolled by the plan for failure to pay plan premiums on July 1. Mr. Smith mails in his past due amounts to the plan on July 30. He contacts the plan and makes his request on August 10, and does not receive a favorable good cause determination. Mr. Smith may not be reinstated.

Example C: Mr. Smith is disenrolled by the plan for failure to pay plan premiums on November 1. Mr. Smith mails in his owed amounts to the plan on December 15, but does not contact the plan to request reinstatement. Thus, Mr. Smith does not have a favorable good cause determination, and he may not be reinstated.

NOTE: In cases where the involuntary disenrollment for failure to pay plan premiums is the result of plan error, plans should follow the reinstatement process outlined in Section 60.3.3. Plans should not refer these individuals to 1-800-MEDICARE, nor should these cases be considered for reinstatement for good cause.

60.3.4.2 – Process for Good Cause Determinations for Nonpayment of Part D-IRMAA

When a disenrolled individual contacts the MA organization following disenrollment for failure to pay Part D-IRMAA and indicates that he or she "has a good reason for not paying the Part D-IRMAA," the MA organization must advise the individual to contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) within 60 calendar days of the disenrollment effective date to make the good cause reinstatement request. The organization should also inform the individual that in order to be reinstated, he or she must meet specific good cause standards and must pay all overdue plan premiums and Part D-IRMAA amounts within three (3) months of the disenrollment date in order for reinstatement to occur.

Once a request is made with CMS via 1-800-MEDICARE, a Complaint Tracking Module (CTM) case will be generated for CMS caseworker action. The CMS caseworker will review the request and will make a favorable or unfavorable good cause determination. If the individual provides any documentation to the plan regarding the inability to make timely payment of the Part D-IRMAA, the plan must provide that documentation to CMS (through the CMS account manager) so that it may be considered in making the determination. If CMS makes an unfavorable determination, CMS will

notify the individual of the determination. Notes of the good cause reinstatement request will be captured in the CTM for CMS and plan viewing.

NOTE: Requests for reinstatement are not considered complaints against the plan; therefore, these types of CTM cases are excluded from tracking for the purposes of plan ratings.

If CMS makes a favorable determination, a notation will be made in the CTM and the CTM will be sent to the plan. If there are amounts owed to the plan for past due premiums, the plan should send notification to the individual within three (3) business days of being informed of the favorable good cause determination. This notice will specify the amount owed, the date by which payment must be received for reinstatement (i.e., last day of the third month following effective date of disenrollment), where to send payment, and other payment options such as credit card or direct withdrawal from a bank account, if offered by the plan. (See Exhibit 22a).

Plans have additional time beyond the payment deadline (i.e., three months from the disenrollment effective date) to verify payment by the bank and credit the payment to the individual's account. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five (5) calendar days beyond the payment deadline to process the payment and notify CMS via CTM. Even if an individual has received a favorable good cause determination, the actual reinstatement will not occur until all required payments are made within three (3) months of the disenrollment effective date.

Within ten (10) calendar days of receipt of *D*TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a). In an effort to prevent members from falling behind in premium payments in the future, plans are encouraged to educate them on any automated payment mechanisms offered by the plan, as well as the availability of automatic premium withhold from SSA or RRB benefits.

An individual may not be reinstated in cases where:

- the individual pays all Part D-IRMAA amounts and any plan premium amounts owed, but does not receive a favorable good cause determination; or
- the individual receives a favorable good cause determination, but does not pay the Part D-IRMAA amounts and/or any plan premiums owed with three (3) months of the disenrollment effective date.

In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request, but only if he or she has a valid election period (i.e., AEP, SEP, etc.), following enrollment procedures outlined in Sections 30 and 40.

Example: Mr. Smith is disenrolled by CMS for failure to pay Part D-IRMAA on August 1. He contacts Medicare and makes his request on September 29 and receives a favorable good cause determination on October 5. Mr. Smith is also delinquent on his plan premiums. CMS notifies Mr. Smith that he must pay the Part D-IRMAA amount he owes by October 31. The plan notifies Mr. Smith that he must also pay the plan premium amount he owes by October 31. Mr. Smith pays his Part D-IRMAA owed amount on October 25. Mr. Smith pays his plan premium owed amount on November 5. Because the plan received Mr. Smith's payment for his owed plan premium amount after the due date, Mr. Smith may not be reinstated. (Note: If Mr. Smith had paid both his owed Part

D-IRMAA and plan premiums by October 31, the plan would have had the additional five (5) days to process the payment and he would have been reinstated.)

60.4 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the MA organization or CMS is unable to process the enrollment for the required effective date (as outlined in §30.5), CMS (or its designee) will process a retroactive enrollment.

In addition, auto-enrollment for full-benefit dual eligible as described in §40.1.5 may be retroactive to ensure no coverage gap between the end of Medicaid coverage for Part D drugs and the beginning of Medicare drug coverage.

In other limited cases, CMS may determine that an individual is eligible for an SEP due to an extraordinary circumstance beyond his/her control (e.g. a fraudulent enrollment request or misleading marketing practices) and may also permit a retroactive enrollment in an MA plan as necessary to prevent a gap in coverage or liability for the late enrollment penalty.

Unlike a reinstatement, which is a correction of records to "erase" an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period. Therefore, retroactive enrollments may NOT be made back to a date when an MA plan was closed for enrollment.

> **NOTE:** Keep in mind that unless an approved capacity limit applies, all MA plans are open for ICEP, IEP/D, AEP and SEP enrollment requests; therefore, all MA plans are open for retroactive enrollments for these types of enrollment requests.

Occasionally, obtaining the information necessary to complete an enrollment request within the allowable timeframes will extend beyond the CMS systems cut-off date for transaction submission, thus making the effective date of enrollment "retroactive" to the current payment month. MA organizations must use the Code 61 enrollment transaction to submit the enrollment transaction directly to CMS within the Current Calendar Month transaction processing timeframe.

When a valid request for enrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, MA organizations are required to submit the appropriate documentation to CMS (or its designee) for manual review and potential action. The request for a retroactive enrollment should be made within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. When an individual has fulfilled all enrollment requirements, but the organization or CMS has been unable to process the enrollment in a timely manner, the following documentation must be submitted to CMS (or its designee):

- A copy of signed completed enrollment form (the form must have been signed by the beneficiary (or authorized representative) and received by the organization prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage); or
- A copy of the enrollment request record (the enrollment request record must show that the enrollment request was made and received by the organization prior to the requested effective date of coverage).

The retroactive enrollment request may be denied if CMS determines that the MA organization did not notify the member that he/she must use MA plan services during the period covered by the retroactive enrollment request.

If the request for retroactive enrollment action is due to plan error, the organization must provide a clear and detailed explanation of the plan error including why the retroactive action is necessary to correct the error. The explanation must include clear information regarding what the organization has communicated to the affected beneficiary throughout the period in question. The organization must also include any relevant information or documentation supporting the requested correction. Such information could include a copy of the enrollment request form (or clear evidence of the use of another enrollment mechanism) and evidence of notices sent to the beneficiary related to or caused by the error.

Special note regarding Regional Office Casework actions

When an MA organization is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the organization must provide the following 2 (two) items as documentation to CMS (or its designee):

- A screen print from the Complaint Tracking Module (CTM) or other documentation showing the CMS RO decision and direction to submit the request to the CMS Retroactive Processing Contractor, and;
- A copy of the enrollment or disenrollment request, if one is available. Occasionally, due to the nature of casework, this item may not be available. When that occurs, the organization should submit a brief statement of explanation for the missing documentation.

60.5 - Retroactive Disenrollments

42 CFR 422.66

If an enrollment was never legally valid (§40.6) or if a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph), which includes not only system error, but plan error (see §10 for a definition of "system error" and "plan error"), CMS (or its designee) may grant a retroactive disenrollment. CMS (or its designee) may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §50.2.1.2), a contract violation (as outlined in 42 CFR 422.62(b)(3)) or other limited exceptional conditions established by CMS (e.g. fraudulent enrollment or misleading marketing practices).

When a valid request for disenrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, MA organizations are required to submit the appropriate documentation to CMS (or its designee) for manual review and potential action. Retroactive disenrollment requests can be submitted to CMS (or its designee) by the beneficiary or an MA organization. Requests from an MA organization must include a copy of the disenrollment request, as well as an explanation as to why the disenrollment was not processed correctly. MA organizations must submit retroactive disenrollment requests to CMS (or its designee) within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. If CMS approves a request for retroactive

disenrollment, the MA organization must return any premium paid by the member for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the MA organization (or by the member) to CMS (or its designee) in cases in which the MA organization has not properly processed a required involuntary disenrollment or acted upon the member's request for disenrollment as required in §50.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §30.6.

If the request for retroactive disenrollment action is due to the MA organization's confirmation of an incarcerated status with a retroactive start date (see § 50.2.1.3), the organization must provide written confirmation of the incarcerated status, including the start date. Such confirmation could include documentation of telephonic communications.

If the request for retroactive action is due to plan error, the organization must provide a clear and detailed explanation of the plan error including why the retroactive action is necessary to correct the error. The explanation must include clear information regarding what the organization has communicated to the affected beneficiary throughout the period in question, including evidence that the beneficiary was notified prospectively of the disenrollment. The organization must also include any relevant information supporting the requested correction. Such information could include a copy of the disenrollment request and evidence of notices sent to the beneficiary related to or caused by the error in question and which demonstrate that the retroactive disenrollment is appropriate under the circumstances.

60.6 - Retroactive Transactions for Employer/Union Group Health Plan (EGHP) Members

In some cases an MA organization that has a contract with an EGHP arranges for the employer or union to process enrollment requests for Medicare-entitled group members who wish to enroll in an employer or union sponsored MA plan. However, there can be a delay between the time the member completes the enrollment request through the EGHP and when the enrollment request is received by the MA organization. Therefore, retroactive transactions for these routine delays may be necessary and are provided for under this section. Errors made by an EGHP, such as failing to forward a valid enrollment or disenrollment request within the timeframes described below, must be submitted to CMS (or its designee) for review. Repeated errors may indicate an ongoing problem and therefore will be forwarded to the MA organization's CMS Account Manager for compliance monitoring purposes. The MA organization's agreement with the EGHP must include the need to meet the requirements provided in this chapter that ensure the timely submission of enrollment and disenrollment requests to reduce the need for retroactivity and to help avoid such errors.

60.6.1 - EGHP Retroactive Enrollments

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

The effective date of EGHP enrollments cannot be earlier than the date the enrollment request was completed by the beneficiary. The effective date may be retroactive up to, but may not exceed, 90 days

from the date the MA organization received the request (which was completed prior to the effective date) from the employer or union group.

EXAMPLE

In March 2007, the CMS system processing date was March 13, 2007. Enrollment requests processed by CMS for the March 13, 2007, due date were for the prospective April 1, 2007, payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30, 60 and 90 days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP enrollment request were to be received by the MA organization on March 5, 2007, the retroactive effective date could be January 1, February 1, or March 1, as long as the enrollment request was completed prior to the effective date.

> **NOTE:** Keep in mind that unless a CMS-approved capacity limit has been reached, all MA plans are open for ICEP, AEP, and SEP enrollment requests. Therefore, all MA plans are open for retroactive enrollments for these types of enrollment requests.

No retroactive enrollments may be made unless the individual certifies that the MA organization (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The MA organization should submit such enrollments using the appropriate transaction code. Refer to the Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) for more information. The ability to submit limited EGHP retroactive enrollment transactions is to be used only for the purpose of submitting a retroactive enrollment into an EGHP made necessary due to the employer's delay in forwarding the completed enrollment request to the MA organization.

60.6.2 - EGHP Retroactive Disenrollments

The MA organization must submit a retroactive disenrollment request to CMS (or its designee) if an EGHP does not provide the MA organization with timely notification of a member's requested disenrollment. Up to 90 day's retroactive **payment** adjustment is possible in such a case to conform to the adjustments in payment described under 42 CFR 422.308(f)(2). The EGHP notification is considered untimely if it does not result in a disenrollment effective date as outlined in §30.6.

The MA organization must submit a disenrollment notice (i.e., documentation) to CMS (or its designee) demonstrating that the member acted to disenroll in a timely fashion (i.e., prospectively), but that the EGHP was late in providing the information to the MA organization. Such documentation may include an enrollment form for a new MA plan signed by the member and given to the EGHP during an open enrollment season. The documentation may not include a copy of a Medicare supplemental plan or Medigap plan enrollment form unless the member indicated on that form that he/she has canceled any other insurance. Such documentation should be sent to CMS (or its designee) as soon as possible.

60.7 – User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

Upon receipt of a CMS transaction reply, MA organizations must update their records to accurately reflect each individual's enrollment status. Organizations are also required to provide certain notices

and information to beneficiaries when enrollment status is confirmed or changes. In the case of UI-TRC replies, the standard operating procedures for providing these notices and/or information may not fit some of the unique situations many UI enrollment changes address.

The table below provides guidelines for communicating with beneficiaries when enrollment changes are reported to MA organizations using the "700 series" TRCs that result from UI enrollment changes. In all cases, organizations will need to review the situations carefully to determine the necessity and appropriateness of sending notices. Some UI enrollment change processes will result in multiple 700-series TRCs being reported. Organizations must determine the final disposition of the beneficiary to ensure the correct message is provided in any notice sent. In complex situations, CMS encourages organizations to communicate directly (such as by telephone) with the beneficiary, in addition to any required notice or materials. When it is necessary to send a notice, organizations must issue the notice within ten calendar days of receipt of the *D*TRR.

TRC	Beneficiary Communication Action
701 – New UI Enrollment	Organizations may use existing confirmation notices as provided in CMS enrollment guidance. If such notice has already been provided with the same information, it is not necessary to provide it a second time.
702 – New UI Fill-in Enrollment	Organizations must use Exhibit 30, "Enrollment Status Update." Include the date range covered by the new fill-in period.
703 – UI Enrollment Cancel	If a cancellation notice applicable to this time period has already been provided, it is not necessary to provide it a second time. If notice has not been provided, organizations may use the existing cancellation of enrollment notice as provided in CMS enrollment guidance. If the specific situation warrants, organizations may use Exhibit 30 instead, providing information that clearly indicates that the enrollment period in question has been cancelled. Include information about the refunding of plan premiums, if applicable.
704 – UI Enrollment Cancel - PBP Change	If the UI action is a correction to a plan submission error, the organization may have already provided the correct plan (PBP) information; if that's the case, it is not necessary to send it a second time. If the beneficiary has not received information about the specific plan (PBP), the organization must send the materials required in CMS enrollment guidance that would be provided for any new enrollment. Organizations must also send Exhibit 30 describing the plan change, including the effective date. The impact of the change on plan premiums, cost sharing, and provider networks must be communicated clearly. It is not necessary to confirm with a notice the associated "enrollment canceled" TRC that will accompany the enrollment into the new plan (PBP).
705 – New UI Enrollment - PBP Change	Follow the guidance provided above for TRC 704.
706 – UI Enrollment Cancel - Segment change	Plan (PBP) segment changes apply only to MA plans. Provide updated materials reflecting the new elements of the changed segment, such as premium and cost sharing increases or decreases.
707- UI New enrollment - Segment Change	Follow the guidance above for TRC 706.

708 – UI End Date Assigned	This UI action has the same effect as a plan submitted disenrollment (code 51) transaction. Generally, organizations should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated changes are retroactive, organizations may have already provided notice (with correct effective dates) and if so, need not provide it a second time. Additional clarification may be appropriate depending on the specifics of the case.
709 – UI Earlier Start Date	An existing enrollment period in the plan has changed to start earlier than previously recorded. If the organization has already provided notice reflecting this effective date of enrollment, it is not necessary to provide it a second time. When the individual has not already received notice reflecting this effective date, organizations may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, organizations may use Exhibit 30, including in it the new effective date and information about additional premium liability (ensure flexibility in allowing payment arrangements where necessary). Organizations must also ensure individuals are fully aware of how to access coverage of services for the new time period, including their right to appeal.
710 – UI Later Start Date	An existing enrollment period start date has been changed to start on a later date. Organizations must use Exhibit 30. Organizations must explain the change in the effective date of coverage, and provide information on the refunding of any premiums paid. Organizations must also explain the impact on any paid claims from the time period affected.
711 – UI Earlier End Date	An enrollment period end date has been changed to occur earlier. Organizations must use Exhibit 30. Organizations must explain the change in the effective date of the end of coverage, and provide information on the refunding of any premiums paid. Organizations must also explain the impact on any paid claims from the time period affected.
712 – UI Later End Date	An enrollment period end date has been changed to occur later. Organizations must use Exhibit 30. Organizations must explain the change in the effective date of the end of coverage, and provide information on any premiums the individual may owe for the extended period. Organizations must also ensure beneficiaries are fully aware of how to access coverage of services for the new time period.
713 – UI Removed End Date	An enrollment period that previously had an end date is now open (and ongoing). Organizations must use Exhibit 25a to explain the change and that enrollment in the plan is now continuous. Organizations must provide information on any plan premiums and ensure beneficiaries are fully aware of how to access coverage of services for the new time period and going forward.

60.8 - Election of Continuation of Enrollment Option for MA Local Plans

42 CFR 422.54(b)

When a member permanently moves into the MA organization's continuation area, the member must make a positive choice to continue enrollment in the MA local plan. The member does not have to complete and sign a new enrollment form in order for the continuation to occur but must make this choice in a manner described in the MA organization's policy and procedure documents.

The MA organization must verify that the member has established permanent residence in the continuation area. Proof of permanent residence is normally established by the address of the residence, but the MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

The effective date of a continuation of enrollment change generally is the first day of the month after the individual moves into the continuation area.

60.9 - Storage of Enrollment and Disenrollment Records

As stated at 42 CFR 422.60(c)(2), MA organizations are required to file and retain enrollment request forms. MA organizations must retain and have available for evaluation enrollment and disenrollment records for the current contract period and ten (10) prior years (42 CFR 422.504(e)(4)).

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment requests may also be allowed, such as optically scanned forms stored on disk.

Records of MA enrollment and disenrollment requests made by any other enrollment request mechanism (as described in §40.1) must also be retained as above.

Appendices

Summary of
Medicare Advantage Notice and
Data Element Requirements

Appendix 1: Summary of Notice Requirements

Referenced in sections: 10, 30, 40, 50, and 60
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within this guidance.

Notice	Section(s)	Required?	Timeframe
Model Enrollment Form (Exh. 1)	10, 40.1.1, 40.2, 40.4.1	Yes[3]	NA
Information to include on or with Enrollment Mechanism -- Attestation of Eligibility for an Enrollment Period (Exh. 1a)	30.4	No	NA
MA MSA Enrollment Form (Exh 1b)	40.1.1	Yes[4]	NA
MA PFFS Enrollment Form (Exh 1c)	40.1.1	Yes[5]	NA
Simplified Enrollment Form (Exh. 1d)	40.1.9	No	NA
EGHP Enrollment Form (Exh. 2)	10, 40.1.1, 40.2, 40.4.1	No	NA
Short Enrollment Forms (Exh. 3 and 3a)	10, 40.1.1, 40.2, 40.4.1	No	NA
Acknowledgment of Receipt of Completed Enrollment Request (Exh. 4 and 4a)	40.4.1, 60.4	Yes[6]	10 calendar days of receipt of completed enrollment request
Combination Acknowledgement and Confirmation Notice (Exh. 4b)	40.4	Yes[7]	7 calendar days of availability of the *D*TRR
Acknowledge Receipt of Completed PFFS Enrollment Request (Exh.4c)	40.4.1, 60.4	Yes[8]	10 calendar days of receipt of completed enrollment request
Notice to Acknowledge Receipt of Completed PFFS Enrollment Request and to Confirm Enrollment in a PFFS Plan (Exh. 4d)	40.4.1, 60.4	Yes	7 calendar days of availability of the *D*TRR

[3] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[4] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[5] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[6] Required unless combined acknowledgment/confirmation notice is issued.
[7] Required if the MAO has chosen to provide a single notice in response to the *D*TRR, as described in §40.4.1.
[8] Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section(s)	Required?	Timeframe
Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment in Another Plan Within the Same Parent Organization (Exh. 4e)	40.4	Yes	7 calendar days of the availability of the *D*TRR
Request for Information (Exh. 5)	30, 40.2.2	No	10 calendar days of receipt of enrollment request
Confirmation of Enrollment (Exh. 6,6a, 6d)	40.4.2, 40.6	Yes[9]	10 calendar days of availability of *D*TRR
Notice to Individuals Identified on CMS Records As Members of Employer or Union Group Receiving Retiree Drug Subsidy (Exh. 6b)	40.2.5	Yes	10 calendar days of availability of *D*TRR
Confirm PFFS Enrollment (Exh. 6c)	40.4.2	Yes[10]	10 calendar days of availability of *D*TRR
MAO Denial of Enrollment (Exh. 7)	40.2.3	Yes	10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information
CMS Rejection of Enrollment (Exh. 8)	40.4.2	Yes	10 calendar days of availability of *D*TRR (exception described in §40.4.2)
Sending Out Disenrollment Form/Disenrollment Form (Exh. 9, 9a, & 10)	50.1	No	NA
Information to include on or with Disenrollment Form -- Attestation of Eligibility for an Election Period (Exh. 10a)	30.4	No	NA
Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)	50.1, 50.4.1	Yes	10 calendar days of receipt of request to disenroll
Request Information (Disenrollment) (Exh. 11a)	30, 50.4.2	Yes	10 calendar days of receipt of disenrollment request

[9] Required unless combined acknowledgment/confirmation notice is issued.
[10] Required unless combined acknowledgment/confirmation notice is issued.

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Notice	Section(s)	Required?	Timeframe
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	50.1	No	NA
Confirmation of Voluntary Disenrollment Identified Through *D*TRR (Exh. 12)	50.1, 50.4.1. 60.3.2	Yes	10 calendar days of availability of *D*TRR
Denial of Disenrollment (Exh. 12a)	50.1.4	Yes	10 calendar days of receipt of disenrollment request
Rejection of Disenrollment (Exh. 12b)	50.1	Yes	10 calendar days of availability of *D*TRR
Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan (Exh. 12c)	50.4.1	Yes	10 calendar days of availability of *D*TRR
Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	No	NA
Disenrollment Due to Death (Exh. 13)	50.2.3, 50.4.2, 60.3.1	No	NA
Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14)	50.2.2, 50.4.2, 60.3.1	No	NA
Notices on Terminations/Non-renewals	50.2.4	Yes	Follow requirements in 42 CFR 422.506 - 422.512
Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	50.3.2	Yes	NA
Disenrollment for Disruptive Behavior (no exhibit)	50.3.2	Yes	Before the disenrollment transaction is submitted to CMS
Disenrollment for Fraud and Abuse (no exhibit)	50.3.3	Yes	Before the disenrollment transaction is submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending	60.3, 60.3.1	Yes	10 calendar days of initial contact with member

Notice	Section(s)	Required?	Timeframe
Correction of Disenrollment Status Due to Plan Error (Exh 17)			
Closing Out Request for Reinstatement (Exh. 18)	60.3.2	Yes	10 calendar days after information was due to MA organization
Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)	50.3.1	Yes	Within 15 calendar days of the premium due date
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	50.3.1	Yes	3 business days following the last day of the grace period
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	50.3.1	No	NA
Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount (Exh. 21a)	50.2.6	Yes	10 calendar days of notification on the *D*TRR
Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22)	50.3.1	Yes	10 calendar days of the expiration of the grace period
Notice of Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement (Exh. 22a)	60.3.4	No	3 business days following the notification by CMS of favorable good cause determination
Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Premium Amount Due for Reinstatement (Exh 22b)	60.3.4	No	3 business days following favorable good cause determination
Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (Exh 22c)	60.3.4	No	3 business days following unfavorable good cause determination
Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment (Exh 22d)	60.3.4	Yes	10 calendar days of the expiration of the 3 month period

Notice	Section(s)	Required?	Timeframe
Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement) (Exh 22e)	60.3.4.1	No	3 business days following favorable good cause determination
Public Notices For Closing Enrollment due to Capacity Limit (Exh. 23)	40.5	Yes	15 days if related to CMS approved capacity limit
Notice that Enrollment request Placed on Waiting List (no exhibit)	40.5.1, 40.5.2	Yes	10 calendar days of receiving enrollment request or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll (no exhibit)	40.5.1, 40.5.2	No	10 days of contacting member
Intent to Not Process Enrollment (no exhibit)	40.5.1, 40.5.2	Yes	10 calendar days of learning beneficiary no longer wants to enroll
Medigap Rights per Special Election Period (Exh. 24)	50.2, 50.1	No	Upon request.
Request to cancel enrollment (Exh. 25)	60.2.1	Yes	10 calendar days of request
Confirmation of Reinstatement Per Notification From CMS (Exh. 25a)	60.2.1, 60.2.2, 60.3, 60.3.1, 60.3.2	Yes	10 calendar days of *D*TRR confirming reinstatement
Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)(Exh. 25b)	60.2.4	Yes	10 calendar days of *D*TRR confirming cancellation
Request to cancel disenrollment (Exh. 26)	60.2.2	Yes	10 calendar days of request
Inform Member of Auto-Enrollment (Exh. 27)	40.1.5	Yes	10 calendar days of identifying individual as needing auto-enrollment
Inform FBDE Member of Auto-Enrollment in PDP (Exh. 27a)	40.1.5	Yes	10 calendar days of identifying individual as needing auto-enrollment
Inform Member of Facilitated Enrollment (Exh. 28)	40.1.5	Yes	10 calendar days of identifying individual as needing facilitated enrollment

Notice	Section(s)	Required?	Timeframe
Inform Member of Facilitated Enrollment into PDP (Exh. 28a)	40.1.5	Yes	10 calendar days of identifying individual as needing facilitated enrollment
Request to Decline Part D (Exh. 29)	40.1.5	Yes	10 calendar days of request
Enrollment Status Update (Exh. 30)	60.7	As necessary	10 calendar days of availability of *D*TRR
Model Employer/Union Group Enrollment Mechanism Notice (Exh 31)	40.1.6	Yes	21 calendar days prior to effective date of enrollment
Loss of SNP Status (Exh 32)	50.2.5	Yes	10 calendar days of loss of special needs status
Loss of SNP Status - Notification of Involuntary Disenrollment (Exh 33)	50.2.5	Yes	3 business days of expiration of period of deemed continued eligibility
Research Potential Out of Area Status (Exh 34)	50.2.1.3	Yes	10 calendar days of receiving notice of change of address or indication of possible out-of-area residency
Disenrollment Due to Out of Area Status (No Response to Request for Address Verification) (Exh 35)	50.2.1.3	Yes	Within first 10 calendar days of the sixth month.
Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member) (Exh 36)	50.2.1.3	Yes	10 calendar days of receiving confirmation of out of area status
Exhibit 37: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration	50.2	Yes	10 calendar days of notification on the *D*TRR
Exhibit 38: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence	50.2.1, 50.2.7	No	10 calendar days of notification on the *D*TRR

Appendix 2: Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests

Referenced in section(s): 20, 20.4, 40.2, 40.4.1
(Rev. 2, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

All data elements with a "Yes" in the "Beneficiary response required on request" column are necessary in order for the enrollment election to be complete. For use of simplified enrollment mechanism, the plan must be able to obtain, from its internal data sharing, all the required elements that it does not include on the enrollment request. Elements required on the simplified enrollment mechanism, regardless of data sharing, are marked with an asterisk (*).

Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
1	MA Plan name[11]	Yes*	Yes	1, 1b, 1c, 2, 3, 3a
2	Beneficiary name	Yes*	Yes	1, 1b, 1c, 2, 3, 3a
3	Beneficiary Date of Birth	Yes	Yes	1, 1b, 1c, 2
4	Beneficiary Sex	Yes	Yes	1, 1b, 1c, 2
5	Beneficiary Telephone Number	Yes*	No	1, 1b, 1c, 2, 3
6	Permanent Residence Address (with the exception of "County" – see below)	Yes	Yes	1, 1b, 1c, 2, 3
7	County (Optional Field)	No	No	1, 1b, 1c, 2, 3
8	Mailing Address	Yes	No	1, 1b, 1c, 2, 3
9	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	No	1b, 1c, 2
10	E-mail Address (Optional Field)	No	No	1, 1b, 1c, 2, 3
11	Beneficiary Medicare number	Yes*	Yes	1, 1b, 1c, 2, 3
12	Additional Medicare information contained on Medicare card, or copy of card[12]	No	No	1b, 1c, 2
13	Plan Premium Payment Option	Yes[13]	No[14]	1, 1b, 1c, 3, 3a
1*4*	Response to long term care question	No	No	1, 1b, 1c, 2

[11] If enrollment mechanism will be used for multiple plans, all plan names must be listed in a way that permits the applicant to clearly indicate his/her plan choice.
[12] Plans may include the image of the Medicare card in enrollment mechanisms.
[13] Zero premium MA-only plans omit this question
[14] Response defaults to direct bill if applicant fails to provide information

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Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
15	Response to other insurance COB information	Yes	Yes[15]	1b, 1c, 2
16	Option to request materials in language other than English (language preference) or in accessible formats	Yes*	No	1, 1b, 1c, 2, 3, 3a
17	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	No	2
18	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	No	2
19	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	No	2
20	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No	No	1, 1b, 1c, 2, 3
21	Beneficiary signature and/or Authorized Representative Signature	Yes*	Yes[16]	1, 1b, 1c, 2, 3,3a
22	Date of signature	Yes*	No[17]	1, 1b, 1c, 2, 3, 3a
23	Authorized representative contact information	Yes*	Yes	1, 1b, 1c, 2,3, 3a
24	Employer or Union Name and Group Number	Yes	Yes	2
25	Question of which MA plan the beneficiary is currently a member of and to which MA plan the beneficiary is changing	Yes	Yes	3

[15] Refer to CMS COB guidance for additional information

[16] For Employer/Union Group MA enrollment elections as described in §40.1.6, and some other CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, organization may verify with the applicant by telephone and document the contact instead of returning form.

[17] As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the MA organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element. For employer group MA elections as described in §40.4.1, the "signature date" is the date the employer's process was completed as recorded.

Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
26	For Special Needs Plans, description of SNP eligibility criteria	Yes	Yes	N/A
27	For MSA plans, all additional elements including proof that MSA bank account has been established	Yes	Yes	N/A
28	Information provided under "please read and sign below" All elements provided in model language must be included on enrollment request mechanisms. Option -- can be provided as narrative or listed as statements of understanding	Yes*	Yes	1, 1b, 1c, 2
29	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes*	Yes	1, 1b, 1c, 2
30	Notification of receiving plan materials electronically and ability to opt out	No	No	1, 1b, 1c, 2, 3, 3a

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Appendix 3: Setting the Application Date on CMS Enrollment Transactions

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the beneficiary's choice of plan is honored. The application date is always a date prior to the effective date of enrollment. For use of simplified enrollment mechanism, follow the information based on how the enrollment request is received (e.g., paper, fax, telephone, electronically.)

Enrollment request Mechanism	**Application Date**	**Special Notes**
Paper Enrollment Forms §40.1.1	The date the paper request is initially received	Paper requests submitted to or collected by sales agents or brokers are received by the MA organization on the date the agent or broker receives the form
Enrollment forms received by Fax §40.1.1	The date the fax is received on the MA organization's Fax machine	
Medicare.gov Online Enrollment Center (OEC) §40.1.2	11 hours prior to the time and date "stamped" by CMS on the request	Refer to the definition of Application Date in §10.
MA organization electronic enrollment process §40.1.2	The date the enrollee completes the request via the electronic enrollment process	The electronic enrollment process must capture the application date as the day that the individual completes the request as part of the process itself.
Approved Telephonic Enrollment §40.1.3	The date of the call	
Default Enrollment Option for Newly MA Eligible Medicaid Managed Care Plan Enrollees §40.1.4	First day of individual's Initial Coverage Election Period (ICEP)	Effective date must always be the date of the individual's first entitlement to **both** Medicare Part A and Part B
Other Special Processes for Application Dates	**Application Date**	**Special Notes**
All enrollment requests into employer or union sponsored plans using the SEP EGHP, regardless of mechanism used	1st day of the month prior to the effective date of enrollment	This applies to all mechanisms including §§40.1.3 and 40.1.6
Auto and Facilitated Enrollment §40.1.5	The 1st of the month prior to the effective date of the auto/facilitated enrollment	
SPAP enrollment requests as permitted in §40.1.8 made during the AEP	October 15th	The effective date of enrollment is the following January 1st

Appendix 4: Examples of Good Cause Determinations

Referenced in section: **60.3**

This listing is to provide examples to assist plans in making favorable and unfavorable determinations for requests of reinstatement for good cause. For exact detail on the criteria and requirements for good cause reinstatements, see §60.3.

In all these examples, the individual is disenrolled for nonpayment of plan premiums and makes a timely request for good cause reinstatement.

Favorable determination examples:

Example A: Ms. Grey was disenrolled on May 31, 2015 following a plan's two month grace period. She states that she has a caregiver who is responsible for making her premium payments to the plan. Ms. Grey attests that her caregiver caught pneumonia, was hospitalized for over 2 months from late March to late May 2015 and wasn't able to make payments. The plan issues a favorable good cause determination, since the member's caregiver was unexpectedly ill and hospitalized for a significant portion of the plan's grace period, which prevented the caregiver from making arrangements for timely payment. The plan's favorable determination is appropriate because: 1) The credible statement was provided about a serious illness and the person paying premiums was hospitalized for a significant portion of the plan's grace period; 2) The event (illness and hospitalization) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the caregiver could not have paid or made arrangements to pay the owed premiums within the plan's grace period as a result of the illness and hospitalization.

Example B: Mr. Lieber was disenrolled on April 30, 2015 following a plan's two month grace period. He states that he was in a car accident in mid-February, was hospitalized for one month and then sent to an assisted living facility for rehabilitation for one month. He indicated that he wasn't able to pay his bills during that time and didn't have any family to assist him. Because Mr. Lieber's situation was unexpected and he was hospitalized and institutionalized for a significant portion of the plan's grace period, the plan issues a favorable good cause determination. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about a serious illness and that the member was hospitalized and institutionalized for significant portion of the plan's grace period ; 2) The event (illness and hospitalization) was unexpected and out of the person's control; and 3) It is reasonable to conclude that Mr. Lieber could not have paid or made arrangements to pay the owed premiums within the plan's grace period as a result of the illness.

Example C: Ms. Kim was disenrolled on August 31, 2015 following the plan's two month grace period. She states that she was displaced from her apartment due to a building fire in early June, was unable to access her belongings and as a result, was unable to make timely payment. The plan issues a favorable determination because Ms. Kim's home was significantly damaged by an unexpected and uncontrollable event during the plan's grace period. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about that the member's home was severely damaged due to an unexpected event; 2) The event (fire) was unexpected and out of the person's control; and 3) It is reasonable that the damage to Ms. Kim's home impaired her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example D: Mr. Jones was disenrolled on June 30, 2015 following a plan's two month grace period. His son states that he found out that his father lost his coverage when he recently visited him. The son states that Mr. Jones was recently diagnosed with dementia and his condition is quickly worsening, which caused him to not pay his premiums. The son states that because of his father's condition, he is taking over financial matters for his father and will pay the arrearages. The plan issues a favorable determination because Mr. Jones was newly diagnosed with a serious illness that directly impacts his ability to pay his premiums. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about a serious and prolonged illness with rapid deterioration, that directly impacted the member's ability to pay premiums timely; 2) The event (serious illness with rapid deterioration) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the onset of dementia caused Mr. Jones to fail to make the timely payment during the grace period.

Example E: Ms. Brown was disenrolled on July 31, 2015 following the plan's three month grace period. She states that for the past four months, her husband was receiving intensive treatment for cancer and she was taking care of him during this time. During this time, she fell behind in paying bills due to the care he needed. The plan issues a favorable determination because Ms. Brown's husband was seriously ill for a prolonged period time during the plan's grace period. The plan's favorable determination is appropriate because: 1) The credible statement was provided about a serious and prolonged illness of an immediate family member; 2) The event (serious and prolonged illness) was unexpected and out of the person's control; and 3) It is reasonable to conclude that Ms. Brown's circumstance in providing caregiver services for her spouse impacted her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example F: Mrs. Duke was disenrolled on August 31, 2015 following the plan's two month grace period. She states that her husband had been handling her bills and making payments timely. However, he passed away in July 2015, leaving her with no caregiver or family member to take over the responsibility. The plan issues a favorable good cause determination because of the recent death of Mrs. Duke's husband, which was unexpected and out of her control. The plan also offers Mrs. Duke the option to set up electronic payments and premium withholding to help ensure that she remains current in paying her premiums. The plan's favorable determination is appropriate because: 1) The credible statement was provided about the recent death of a spouse; 2) The event (death of spouse) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the unexpected death impacted Mrs. Duke's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example G: Mr. Santiago lives in Lucas County, Iowa, and was disenrolled on July 31, 2015 following the plan's two month grace period. He states that there were severe storms and significant flooding in his town and the Post Office closed for a week during the grace period while the flooding receded. The plan checks the FEMA.gov website and verifies that Lucas County, Iowa, was declared as a federal disaster area. The plan issues a favorable good cause determination because the declared federal state of emergency occurred during the plan's grace period and that emergency impacted Mr. Santiago's ability to pay his premiums timely. The plan's favorable determination is appropriate because: 1) The credible statement provided was an extreme weather-related event The event (declared state of emergency) was unexpected and out of the person's control; 2) The event was unexpected and out of the person's control; and 3) It is

reasonable to conclude that this circumstance impacted Mr. Santiago's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Unfavorable determination examples:

Example A: Mr. Smith was disenrolled on June 30, 2015 following the plan's three month grace period. He states that he was unable to pay his plan premiums because he was in the hospital for a week in May for a planned surgical procedure, followed by a two week stay in a rehabilitation facility. The plan issues an unfavorable good cause determination because Mr. Smith was not unexpectedly hospitalized or institutionalized for a significant portion of the plan's grace period. Even though Mr. Smith was away from his home undergoing medical treatment for three weeks, he had a reasonable opportunity and ability to resolve the delinquency within the plan's grace period. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which hospitalization or institutionalization occurred for a significant portion of the plan's grace period; 2) The situation (planned hospital procedure) was not unexpected, nor did it render the individual without control over timely payment of his premiums; and 3) It is reasonable to expect that Mr. Smith could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Smith may not be reinstated for good cause.

Example B: Mr. Jones was disenrolled on May 31, 2015 following the plan's two month grace period. He states that he was unable to pay his plan premiums because he has End-Stage Renal Disease (ESRD) and goes to a facility for dialysis three times a week. Mr. Jones states that he sometimes has difficulty keeping track of his monthly premium billing statements because of his frequent trips to the dialysis facility. The plan issues an unfavorable good cause determination because Mr. Jones has a known health issue and his need for routine dialysis is not unexpected in any way. While he has a chronic illness, he was receiving regular care to treat his condition, and it is reasonable to expect him, or someone acting on his behalf, to resolve the delinquency at some point during the plan's grace period. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which a chronic illness had newly developed serious complications which inhibited the ability to pay premiums timely; 2) The situation (chronic condition with no complications) did not render the individual without control over timely payment of his premiums; and 3) It is reasonable to expect that Mr. Jones could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Jones may not be reinstated for good cause.

Example C: Ms. Ferrera was disenrolled on March 31, 2015 following the plan's two month grace period. She states that she and her family were away from home on an extended vacation and she wasn't aware that she had been disenrolled until they returned home. Ms. Ferrera states that she is willing and able to pay the plan premiums that were not paid and added that she needs her coverage due to her many medications for diabetes. The plan issues an unfavorable good cause determination because Ms. Ferrera did not have a circumstance that was unexpected or unforeseen in any way. While she has a chronic illness and requires medicines to treat her condition, Ms. Ferrera had the ability to make arrangements to have the premiums paid on time while she was out of town. The plan's unfavorable determination is appropriate because: 1) The credible statement provided of being away from home on vacation is listed specifically as the basis for an unfavorable determination; 2) The situation (planned vacation) was not unexpected in any way; and 3) It is reasonable to expect that Ms. Ferrera could have paid or made

arrangements to pay the owed amounts within the plan's grace period. Ms. Ferrera may not be reinstated for good cause.

Example D: Mr. Davis was disenrolled on July 31, 2015 following the plan's two month grace period. He states that earlier in the year he moved a short distance from his previous residence but did not inform the plan of his new address. The plan issues an unfavorable good cause determination because the plan materials clearly state that it is the enrollee's responsibility to inform the plan of a change of address. This is not a case of plan error, since the plan sent the monthly billing statements and the disenrollment notice to the address most recently provided by Mr. Davis. (See §60.3.3 for information on reinstatement following disenrollment due to plan error.) The plan's unfavorable determination is appropriate because: 1) The credible statement provided of an unreported change of address is listed specifically as the basis for an unfavorable determination; 2) The situation (permanent residence change) was not unexpected in any way; and 3) It is reasonable to expect Mr. Davis to inform the plan of his new address, to avoid any delay in his receipt of important materials, such as monthly billing statements and notices regarding his enrollment status. Mr. Davis may not be reinstated for good cause.

Example E: Ms. Adams was disenrolled on April 30, 2015 following the plan's three month grace period. She states that the basement in her home and her electricity were affected by recent flooding and that this prevented her from sending her monthly plan premium payments. Local road closures and power outages lasted for up to a week for some residents. The plan issues an unfavorable good cause determination because the local storms and subsequent flooding did not severely damage Ms. Adams home or prevent her from making the premium payments; further, there was neither a state nor federal disaster declaration. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which the home was severely damaged nor was there a federal or state declaration of emergency; and 2) While road closures and power outages impacted some area residents, it isn't clear that Ms. Adams was directly impacted by these events or was impeded from being able to make timely payment; and 3) It is reasonable to expect that Ms. Adams could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Adams may not be reinstated for good cause**.**

Example F: Mrs. Johnson was disenrolled on March 31, 2015 following the plan's two month grace period. She states that her husband is responsible for making her premium payments to the plan. Mrs. Johnson attests that her husband became ill, was hospitalized for two weeks in February 2015 and was not able to make payments. The plan issues an unfavorable good cause determination since, although her husband's illness was unexpected, he was not hospitalized for a significant portion of the plan's grace period, which would have caused him to be unable to make the payment in a timely manner. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not that hospitalization or institutionalization occurred for a significant portion of the plan's grace period; and 2) It is reasonable to expect that Mr. Johnson could have paid or made arrangements to pay the owed amounts for this wife's coverage within the plan's grace period. Mrs. Johnson may not be reinstated for good cause.

Example G: Mr. Patel was disenrolled on September 30, 2015 following the plan's three month grace period. He states that his income decreased and he was unable to afford to pay his premiums. The plan issues an unfavorable good cause determination because there wasn't an unexpected or unforeseen circumstance that prevented payment from being made by Mr. Patel in a timely manner. The plan's unfavorable determination is appropriate because: 1) The credible statement provided of personal financial issues is listed specifically as the basis for an

unfavorable determination; and 2) It is reasonable to expect that Mr. Patel could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Patel may not be reinstated for good cause.

Example H: Ms. Ulman was disenrolled on June 30, 2015 following the plan's two month grace period. She states that she needs to refill her medications and that she paid her owed amounts to the plan on July 20, 2015, following her disenrollment effective date. The plan issues an unfavorable good cause determination because Ms. Ulman's need for medications did not inhibit her ability to pay her premiums timely. The plan's unfavorable determination is appropriate because: 1) The situation (medication needs) was not unexpected or out of the person's control, nor did it impede her ability to pay timely; and 2) It is reasonable to expect that Ms. Ulman could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Ulman may not be reinstated for good cause.

Example I: Ms. Taylor was disenrolled on March 31, 2015 following a plan's three month grace period. She states that when she enrolled in the plan during the fall open enrollment period, she selected premium withhold as the method of premium payment. She says that she received a premium bill from the new plan for January and, in addition, received a delinquency notice in early January warning of disenrollment at the end of March if she did not pay the premium for January. She stated that she ignored the bill and the delinquency notice, assuming that her plan premiums were being withheld from her Social Security benefit check starting with the January premium. The plan issues an unfavorable good cause determination because the plan explained in its letter to Ms. Taylor following submission of the enrollment transaction and receipt of the *D*TRR that her first month's plan premium was not withheld, that she was responsible for paying her premiums until premium withholding started and that she could be involuntarily disenrolled. The plan concluded that Ms. Taylor had been appropriately advised of her obligation to pay the bill for the January premium and that this was reiterated by means of the subsequent premium bills and the delinquency letter the plan sent to her in January. The plan's unfavorable determination is appropriate because: 1) The situation (misunderstanding of ramifications of nonpayment of premiums) was not unexpected in any way; 2) The situation did not impede her ability to pay timely; and 3) It is reasonable to expect that Ms. Taylor could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Taylor may not be reinstated for good cause.

EXHIBITS

Model Medicare Advantage Enrollment Forms & Notices

This section contains model exhibits for plan issued notices to beneficiaries regarding enrollment matters. MA organizations may make the following modifications to CMS model materials and still submit the material to CMS under the ten (10) day review period: populating variable fields, correcting grammatical errors, changing the font (within standards described in the CMS marketing guidelines), adding the plan name/logo, and adding the CMS marketing material identification number.

For more information on CMS marketing and mailing requirements as well as the instructions for submitting model documents for review, see the CMS Medicare Communication and Marketing Guidelines.

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Exhibit 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
<Plan Name>
<Plan address>
<Plan address>
<Plan address>

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call <Plan Name> at <phone number>. TTY users can call < phone number >.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a <Plan Name> al <phone number/TTY> o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Product ABC – $XX per month ☐ Product XYZ – $XX per month

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

[*MA-PD / PDPs insert:*
Will you have other prescription drug coverage (like VA, TRICARE) in addition to < Plan>? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage

_____ _____ _____]

[Special Needs Plans] insert question(s) regarding the required special needs criteria]

IMPORTANT: Read and sign below:

- [*MA plans insert:* I must keep both Hospital (Part A) and Medical (Part B) to stay in <Plan Name>.]
- By joining this Medicare Advantage Plan, I acknowledge that <Plan Name> will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- [*MA plans insert:* I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services provided by <Plan Name> and contained in my <Plan Name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <Plan Name> will pay for benefits or services that are not covered.]
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

[☐ Plans insert the languages required in your service area.]

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact <plan name> at <phone number> if you need information in an accessible format other than what's listed above. Our office hours are <insert days and hours of operation>. TTY users can call <TTY number.>

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

☐ [*Plans may list those types or categories of materials that are available for electronic delivery]*

E-mail address:

Paying your plan premiums

[Plans with premiums insert: You can pay your monthly plan premium [*MA-PD plans with premiums insert:* (including any late enrollment penalty that you currently have or may owe)] by mail <*insert optional methods*: "Electronic Funds Transfer (EFT)", "credit card"> each month <*insert optional intervals, if applicable, for example* "or quarterly">. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**]

[*MA-PD and PDPs with premiums insert:* **If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period

Referenced in section: 30.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact <plan name> at <phone number> (TTY users should call <TTY number>) to see if you are eligible to enroll. We are open <insert days and hours of operation>.

Exhibit 1b: Model MA MSA Plan Enrollment Request Form ("Election" may also be used)

Referenced in §40.1.1

(Rev. *3*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan name>, Please Provide the Following Information:			
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number: ( )]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field:* **Emergency contact:** _____ **Phone Number**: _____**Relationship to You:** _____]			
[*Optional field:* **E-mail Address:** _____]			

Please Provide Your Medicare Insurance Information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR – • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.
Please read and answer these important questions	

1. To enroll in <MSA plan name>, you may not have other health coverage as described below. Please answer each of the following questions:

A. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

B. Are you receiving Medicare Hospice benefits? ☐ Yes ☐ No

C. Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you aren't eligible to enroll in <MSA plan name>

Will you have other health coverage in addition to <MSA plan name>? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in <MSA plan name>:

Name of other coverage:	ID # for this coverage:	Group # for this coverage
_____	_____	_____

2. Will you reside in the United States for at least 183 days during each year you are enrolled in <MSA plan>?

☐ Yes ☐ No

3. Do you or your spouse work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format:

____ <include list of available languages>

____ <include list of accessible formats (like Braille, audio tape, or large print>

Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.

[*Optional field:* If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

<MSA Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any health coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable

prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15th through December 7th of every year (effective the following January 1st) or under certain limited special circumstances, by sending a request in writing to <MSA plan name>. If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan isn't complete until the bank account is established. I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met, but <plan name> allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50% penalty for withdrawals used for non-medical expenses. After the deductible is met the plan pays 100% of Medicare-covered services.

[*MSA Demonstration Plans insert*: If I am enrolling in a MSA demonstration plan, I may be responsible for cost sharing for certain preventive services, as described by the plan, before the deductible is met. After the deductible is met, I may be responsible for cost-sharing until my expenses for covered services reach the out-of-pocket maximum, after which the MSA demonstration plan pays 100% of Medicare covered services.]

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact the <plan name> at < contact number>.

<MSA plan name> serves a specific service area. If I move out of the area that <MSA Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <MSA plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <MSA plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

I understand that if I disenroll before the end of the plan year (December 31st), <plan name> may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <MSA plan name> will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that

1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____
Keeping records -- As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how the funds are used.

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

Exhibit 1c: Model PFFS Individual Enrollment Request Form ("Election" may also be used)

Referenced in section(s): 10, 20.4, 40.1, 40.2
(Rev. 3, Issued: *August 12*, 2020; Effective/Implementation: 01-01-2021)

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan>, Please Provide the Following Information:			
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number:]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field*: **Emergency contact:** _____ **Phone Number**:_____ **Relationship to You:** _____]			
[*Optional field:* **E-mail Address:** _____]			

Please Provide Your Medicare Insurance Information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR – • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

[***Zero premium MA-only plans omit this section***:
Paying Your Plan Premium

[*Zero premium MA-PD plans insert***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail <***insert optional methods***: "Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example*** "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium [***MA-PD plans with premium insert:*** (including any late enrollment penalty you have or may owe)] by mail <***insert optional methods***: "Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example*** "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.**

[***MA-PD plans with premiums insert:*** **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

☐ Get a bill <option: "coupon", "payment" book, etc>
<*option to include other billing intervals e.g. bi-monthly, quarterly*>

[*Optional - Include other payment methods, such as EFT & credit card as follows:*
☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration Date: _ _/_ _ _ _ (MM/YYYY)]

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)]

Please read and answer these important questions:

[*PFFS-PD plans insert:*

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <PFFS plan>? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ID # for this coverage: Group # for this coverage

_____ _____ _____]

2. Do you or your spouse work? ☐ Yes ☐ No

[*Optional field:* **Please tell us the name of your Primary Care Physician (PCP):**

Doctor's Name: _____ Phone Number: _____]

[*Optional field:* **Please tell us the name of your preferred hospital, clinic or health center:**

Name: _____ City: _____ State: _____]

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

____ <include list of available languages>

____ <include list of accessible formats (like Braille, audio tape, or large print)>

Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.

[*Optional field:* If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

Please Read This Important Information

[*All PFFS plans insert:* <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*All PFFS plans insert, except for cases in which beneficiary is switching from one PFFS plan to another PFFS plan offered by the same MAO*: Once <plan name> has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

[*PFFS-PD plans insert:* If you currently have health coverage from an employer or union, joining <PFFS-PD Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <PFFS-PD Name> may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.]

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

<Plan Name> is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan [*PFFS w/PD insert* "or Medicare prescription drug plan."]. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [*PFFS w/o PD only plans insert:* "I understand that since this plan does not offer Medicare prescription drug coverage, I may get coverage from another Medicare prescription drug plan. If I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future."] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.

As a Medicare Private Fee-For-Service plan, <plan name> works differently than a Medicare supplement plan as well as other Medicare Advantage plans. <Plan name> pays instead of Medicare, and I will be responsible for the amounts that <plan name> doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in <plan name>.

Before seeing a provider, I should verify that the provider will accept <plan name>. I understand that my health care providers have the right to choose whether to accept <plan name>'s payment terms and conditions every time I see them. I understand that if my provider doesn't accept <plan name>, I will need to find another provider that will.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify <plan name> so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow in to get coverage with this Private Fee-For-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [**PFFS-PD plans insert:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	***Today's Date:***

If you are the authorized representative, you must sign above and provide the following information:

Name: _____
Address: _____
Phone Number: *(___)* ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

Exhibit 1d: Model Simplified Enrollment Form

Reference: §40.1.9
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

[MA Organizations must collect all required data as outlined in Appendix 2. Additional data elements must be added for any required data not already available.]

You are requesting enrollment into a Medicare Advantage Plan offered by <name of MA Organization>. You agree to allow <name of MA Organization> to use your personal information we have on file from your current enrollment in <our non-Medicare coverage *[or optionally: name non-Medicare plan]*> to complete your enrollment request.

Tell Us About Yourself:		
LAST Name:	FIRST Name:	Middle Initial:
Your current <non-Medicare plan name> health plan member number:	Your Medicare Number:	(Optional) Part A coverage starts: Part B coverage starts:
Your Telephone Number (in case we need to reach you):		
Tell Us Which Plan You Want to Enroll: [*Include plan names and premiums. If using form for multiple plans, display options for beneficiary to clearly indicate plan choice.*]		
____ Plan A $XX per month _____ Plan B $XX per month [If offering a zero premium plan or reduction of the Part B premium, may delete or modify the references to plan and Medicare premiums:] I understand that this plan may have a different provider network and that I must pay the monthly plan premium in addition to any Medicare Part A and Part B premiums I may owe. *[May include options for premium payment. If not offering options for premium payment, include:* You will get a bill from <plan name> for your monthly premium. Contact <plan name> if you want to pay your premium by <payment options offered by the plan>.*]*		
[Add any other items not available via internal data sharing to collect the remainder of required information]		
Please check one of the boxes if you would prefer that we send you information in a language other than English or in an accessible format: ____ <include list of available languages> ____ <include list of accessible formats (like Braille, audio tape, or large print)> Please contact <plan name> at phone <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation >. TTY users should call <TTY number>.		

You are requesting enrollment into a Medicare Advantage Plan offered by <name of MA Organization>. You agree to allow <name of MA Organization> to use your personal information we have on file from your current enrollment in <our non-Medicare coverage *[or optionally: name non-Medicare plan]*> to complete your enrollment request.

IMPORTANT: Read and Sign Below:	
• <Plan name> is a Medicare Advantage prescription drug plan and has a contract with the Federal government. I must continue to keep both Part A and Part B to stay enrolled in <plan name>. • I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be compensated based on my enrollment in <plan name>. • **Release of Information:** By joining this Medicare Advantage Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. • The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. • I understand that when my <plan name> coverage begins, I must get all of my medical and prescription drug benefits from <plan name>. Benefits and services authorized by <plan name> and contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor <plan name> will pay for benefits or services.** • I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) This person is authorized under State law to complete this enrollment, and 2) Documentation of this authority is available upon request by Medicare.	
Signature:	**Date:**
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Address:
Phone Number:	Relationship to Enrollee:

Exhibit 2: Model Employer/Union Group Health Plan Enrollment Request Form ("Election" may also be used)

Referenced in section(s): 10, 40.1, 40.2, 50.1
(Rev. *3*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan name>, Please Provide the following Information:			
Employer or Union Name:		Group #:	
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number:]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field:* **E-mail Address:** _____]			

Please Provide Your Medicare Insurance Information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR – • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions
1. Are you the retiree? ☐ Yes ☐ No If yes, retirement date (month/date/year): _____ If no, name of retiree: _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No If yes, name of spouse: _____ Name(s) of dependent(s): _____
3. Do you or your spouse work? ☐ Yes ☐ No
4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to <plan name>? ☐ Yes ☐ No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: ID # for Coverage: _____ _____
5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No If "yes" please provide the following information: Name of Institution: _____ Address & Phone Number of Institution (number and street):_____
[*Optional field:* **Please Choose a Primary Care Physician (PCP), clinic or health center:**]
Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format: ____ <include list of available languages> ____ <include list of accessible formats (like Braille, audio tape, or large print)> Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.
[*Optional field:* If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

Please Read and Sign Below
By completing this enrollment application, I agree to the following: <Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may

get in the future. [***MA-only plans insert*:** I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

<Plan Name> serves a specific service area. If I move out of the area that <Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**]

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

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Exhibit 3: Model Short Enrollment Request Form ("Election" may also be used)

(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

This form may be used in place of the model individual enrollment form when a member of a MA plan is enrolling into another MA plan offered by the same parent organization. This form is not applicable to MSA.

Referenced in section(s): 10, 20.4, 40, 40.1

<table>
<tr><td colspan="4">Name of Plan You are Enrolling In: _____</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Medicare Number:_____
(Note: may use "member number" instead of "Medicare Number")</td></tr>
<tr><td colspan="4">Home Phone Number:</td></tr>
<tr><td colspan="4">Permanent Street Address (P.O. Box is not allowed)</td></tr>
<tr><td>City:</td><td>[Optional field: County:]</td><td>State:</td><td>ZIP Code:</td></tr>
<tr><td colspan="4">Mailing Address (only if different from your Permanent Street Address):

Street Address: City: State: ZIP Code:</td></tr>
<tr><td colspan="4">Please fill out the following:

I am currently a member of the _____ plan in _____<MAO name> with a monthly premium of $_____ .

I would like to change to the _____ plan in _____ <MAO name>. I understand that this plan has different health benefits and a monthly premium of $_____ .</td></tr>
<tr><td colspan="4">[Optional Field: Name of chosen Primary Care Physician (PCP), clinic or health center:]</td></tr>
<tr><td colspan="4">Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:
____ <include list of available languages>
____ <include list of accessible formats (like Braille, audio tape, or large print)>
Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.</td></tr>
<tr><td colspan="4">[Optional field: If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]</td></tr>
</table>

[*Zero premium MA-only plans omit this section*]

Your Plan Premium

[*Zero premium MA-PD plans insert***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail <***insert optional methods***: "Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example*** "or quarterly">. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium [***MA-PD plans with premium insert:*** (including any late enrollment penalty you have or may owe)] by mail <***insert optional methods***: "Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example*** "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

[***MA-PD plans with premiums also insert:*** **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

☐ Get a bill <*option: Include other optional methods, such as EFT & credit card*>

☐ Automatic deduction from your monthly Social Security or RRB benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB

does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)]

Please Read This Important Information

[*Insert if enrolling in a PFFS plan:* <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. Your doctor or hospital isn't required to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*Insert if enrolling in a PFFS plan, except for cases in which the member is switching from one PFFS plan to another PFFS plan offered by the same parent organization*: Once <plan name> has your enrollment form, a plan representative will call you. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

Please Read and Sign Below:

<Plan> is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1)

this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[*optional space for other administrative information needed by plan*]

Exhibit 3a: Model Plan Selection Form for MA-PD - Switch From Plan to Plan Within Parent Organization

This form is not applicable to MSA.

Referenced in section(s): 10, 40, 40.1, 40.2
(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <plan name> Member:

<*Introduction - In the introduction of cover letter, MA organization may include language regarding plan choices, description of plans, differences, etc.*>. [*Insert to describe PFFS plans:* <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

To make a change in the Medicare Advantage plan you have with <name of MA organization>, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us <*optional:* in the postage-paid envelope> by <date>.

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.*]*

If you select another plan and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will be <premium amount> and you may continue to see any <current plan name> primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included <year> <Summary of Benefits or benefit overview> for the available options.

If you have any questions, please call <plan name> at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings >. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Plan Selection Form

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Date:
Member Name:
Member Number:

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check the appropriate box below <list all available plans>:

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.>

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.>

[Insert to describe PFFS plans: <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*Zero premium MA-only plans omit this section:*

Your Plan Premium

[*Zero premium MA-PD plans insert***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail <***insert optional methods***: "Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example*** "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium [***MA-PD plans with premium insert:* **(including any late enrollment penalty you have or may owe)] by mail <***insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

Receive a bill <*option: Include other optional methods, such as EFT & credit card*>

Automatic deduction from your monthly Social Security or RRB benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)]

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

____ <include list of available languages>

____ <include list of accessible formats (e.g. Braille, audio tape, or large print)>

Please contact <plan name> at <phone number> (TTY users should call TTY number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>.

[*Optional:* If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: Name: _____ Address: _____ Phone Number: (___) ____- _____ Relationship to Enrollee _____	

Please mail this form to:
<Insert mailing address>

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request

Referenced in section(s): 40.4.1, 60.4
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show at your doctor appointments until you get your member card from us.] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for enrolling in <Plan name>. Beginning <effective date>, you must get your health care as provided in your *<insert either 'Member handbook' or 'Evidence of Coverage'>*. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But, you shouldn't wait to get this letter before you begin using <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[***MA-PD plans with a premium include the following:*** If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[*Plans with a premium include the following:*
How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly premium automatically deducted from your Social Security/Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.] [*MAOs that disenroll for non-payment of plan premiums include the following sentence:* Members who fail to pay the monthly plan premium may be disenrolled from <plan name>.]

What do I need to know about getting health care services?
You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services.

[***MA PPO plans do not use the following paragraph:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.]

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.*]*

[*MA-PD plans with a premium include the following two paragraphs:*
[*Dual-eligible SNPs may omit the following paragraph*]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.]

[*Optional*: **What else do I need to know about my coverage?**
If applicable, insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <days/hours of operation and, if different, *TTY* hours of operation>.

Thank you.

Exhibit 4a: Model Notice to Acknowledge Receipt of Completed Enrollment Request – Enrollment in another Plan Within the Same Parent Organization

Referenced in section(s): 40.4.1, 60.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old Plan name> to <new Plan name>. Starting <effective date>, you must see your <new Plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <new plan name> doctor(s). You will need to pay your plan copayments at the time you get health care services. [*Optional***:** This letter is proof of health insurance that you should show during your doctor appointments.] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Beginning <effective date>, you must get your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **<***Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <new plan name>. But, you shouldn't wait to get this letter before you begin using <new plan name> doctors on <effective date>.

[***MA PPO plans do not use the following sentence:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services**,** if you get health care services from a non-<new plan name> doctor without prior authorization, you will have to pay for these services yourself.]

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for non-payment of plan premium include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[***MA-PD plans with a premium include the following:*** If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[*MA-PD plans with a premium include the following paragraph:]*
[*Dual-eligible SNPs may omit the following paragraph*]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.*]*

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 4b: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment

Referenced in section: 40.4, 60.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?
Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.**

[***MA PPO plans use the following paragraph in place of paragraph above:*** Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Beginning <effective date>, you must get your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [*Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA-PD plans insert the following two paragraphs if no low-income subsidy:***
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[***MA-PD plans add the following paragraph if low-income subsidy applicable:***
What are my costs since I qualify for Extra Help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the Extra Help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call *<plan name>* at *the phone number provided at the end of this letter*. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*:
The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly premium that you owe.]

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.*]* [*If applicable, please insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]*

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact

1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 4c: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Request

Referenced in section(s): 40.4.1, 60.4
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you will begin to get your healthcare from <plan name>. You must show your <Plan name> ID card to your doctor or hospital before you receive healthcare. You may no longer use your red, white and blue Medicare card to receive healthcare, because **Original Medicare won't pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place.

How will this plan work?
<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except in emergencies. You may contact us at the phone number provided at the end of this letter for help locating another provider in your area. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract*

and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. *Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But you shouldn't wait to get that letter before you begin seeing your <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for non-payment of plan premiums include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly premium that you owe.]

What do I need to know about getting health care services?
You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services.

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain

situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*MA-PD plans with a premium include the following two paragraphs:*
What are my costs?
[***MA-PD insert the following if no low-income subsidy:*** The monthly premium for your plan is <insert premium>. *<Explain the charges for which the member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance.>*

[*Dual-eligible SNPs may omit the following paragraph***]**
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.]

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 4d: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Request and to Confirm Enrollment in a PFFS Plan

Referenced in section: 40.4, 60.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?
<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except in emergencies. You may contact us at the phone number provided at the end of this letter for help locating another provider in your area.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. *Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA-PD plans insert the following two paragraphs if no low-income subsidy:***
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[***MA-PD, if low-income subsidy applicable:***
What are my costs since I qualify for Extra Help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the Extra Help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <*plan name*> at *the phone number provided at the end of this letter*. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*:

The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for non-payment of plan premiums include the following sentence:* Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly plan premium that you owe.]

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.*]*

[*If applicable, please insert information instructing member in simple terms how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]*

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to leave (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 4e: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment in Another Plan Within the Same Parent Organization

Referenced in section: 40.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Medicare has approved your enrollment in <new plan name> beginning <effective date>.

How will this plan work?
Beginning <effective date>, you must see your <new plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <new plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.**

[***MA PPO plans use the following paragraph in place of paragraphs above:*** Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Medicare has approved your enrollment in <new plan name> beginning <effective date>. Beginning <effective date>, you must get your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [*Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA-PD plans insert the following two paragraphs if no low-income subsidy:***
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[***MA-PD plans add the following paragraph if low-income subsidy applicable:***
What are my costs since I qualify for Extra Help?
Because you qualify for Extra Help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the Extra Help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information we had from your previous enrollment in <old plan name>. If you have questions about the late enrollment penalty, call <*plan name*> at *the phone number provided at the end of this letter*. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans insert the following for new members who don't have an existing LEP*:
The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

As you did not previously have a late enrollment penalty with us, you will not have a late enrollment penalty with this enrollment change.]

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly premium that you owe.]

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.*]*
[*If applicable, please insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]*

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact

1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 5: Model Notice to Request Information

Referenced in section(s): 30, 40.2.2
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

Thank you for applying with <plan name>. We need additional information from you. Please see the checked items below.

We cannot process your application until we get the following things from you:

_____ Proof of Medicare coverage. Please provide us your Medicare Number. Your Medicare Number is printed on your Medicare card. You can also get your number by:

- Logging into your MySocialSecurity.gov or MyMedicare.gov accounts;
- Calling Medicare at 1-800-MEDICARE (1-800-633-4227; TTY: 1-800-486-2048); or
- Calling Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).

_____ During certain times of the year, Medicare doesn't let you enroll unless you meet certain special exceptions, such as if you qualify for extra help with your prescription drug costs. Please call us at the number below to help us determine if you're able to enroll at this time.

_____ Other: _____

You will need to send this information to <plan name and address> by <date>. You can contact us by phone with this information by calling the phone number below. Or, you may also fax it to us at <fax number> or send it to us at <address>. If we don't get this information by <date>, we will have to deny your request to enroll in our plan.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 6: Model Notice to Confirm Enrollment (MA-PD)

Referenced in section(s): 40.40.2, 40.6

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Please be sure to keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

[I*f no low-income subsidy:*
What are my costs in this plan?
The monthly premium for your plan is: <premium amount>.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name> at the phone number provided at the end of this letter.]

[*If low-income subsidy applicable:*
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[I*nsert the following for new members with an existing LEP:*
Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.] If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.

[*If previous paragraph not applicable, insert the following for all other new members:* If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?
Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 6a: Model Notice to Confirm Enrollment - Plan to Plan Within Parent Organization

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

Please keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

[*MA-PD, if no low-income subsidy:*
What are my costs in this plan?
The monthly premium for your plan is <premium amount>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please call <plan name> at the phone number provided at the end of this letter.]

[*MA-PD, if low-income subsidy applicable:*
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for members with an existing LEP:* Your premium continues to reflect a late enrollment penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get

information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 6b: Model Notice for MA-PD Plans for Individuals Identified on CMS Records As Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)

Referenced in section(s): 40

Dear <Name of Member>:

Thank you for applying with <Plan Name>. To finalize your enrollment, we would like you to confirm that you want to be enrolled in <plan name>.

Medicare has informed us you belong to an employer group or union health plan whose drug coverage is as good as Medicare prescription drug plan coverage.

It is important that you consider your decision to enroll in our plan carefully, since enrollment in <plan name> could affect your employer or union health benefits. You could lose your employer or union health coverage. If you haven't already done so, please contact your benefits administrator to discuss your decision to enroll in a Medicare prescription drug plan.

[*PFFS plans insert*: <Plan Name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

If you have already discussed this decision with your benefits administrator and have decided that you would still like to be a member of <plan name>, **please call** <plan name> **at the phone number provided below. Your enrollment won't be complete until you call and confirm this information.** Your effective date will be <effective date>.

We must hear from you to enroll you in our plan. If we don't hear from you within 30 days from the date of this notice, we won't process your enrollment. If you decide not to enroll in <plan name> you will be responsible for any services you have already received from <plan name>.

To confirm your enrollment or if you have any questions, please feel free to contact <plan name> at <phone number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 6c: Model Notice to Confirm PFFS Enrollment

Referenced in section: 40.4.2

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. You must show your <Plan name> ID card to your doctor or hospital before you get healthcare. Don't use your red, white, and blue Medicare card to receive healthcare, because **Original Medicare won't pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place. [*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [*Optional language for MA-PD***:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

How does this plan work?
<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. As we told you before, <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except for emergencies. You may contact us at the number at the end of this letter for help locating another provider in your area.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract*

and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]

[*MA-PD, if no low-income subsidy:*
What are my costs in this plan?
The monthly premium for your plan is <premium amount>. [*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

[*MA-PD, if no low-income subsidy:*
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name> at the phone number provided at the end of this letter.]

[*MA-PD, if low-income subsidy applicable:*
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. TTY users should call <toll-free TTY number>. You can also get information by visiting

www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 6d: Model Notice to Confirm Enrollment (MA-only)

Referenced in section(s): 40.4.2

<Member # >

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Please be sure to keep a copy of this letter for your records.

What are my costs in this plan?

[*MA-only plans with a premium insert the following:*
The monthly premium for your plan is: <premium amount>.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?
Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 7: Model Notice for MA Organization Denial of Enrollment

Referenced in section(s): 40.2.3
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

Dear <Name of Beneficiary>:

Thank you for applying with <MA Plan>. We cannot accept your request for enrollment in <MA Plan> because:

1. _____ You don't have Medicare Part A.

2. _____ You don't have Medicare Part B.

3. _____ You are unlawfully present in the United States.

4. _____ You are incarcerated and currently reside outside our service area.

5. _____ Your permanent residence is outside our service or continuation area.

6. _____ You attempted to enroll outside of an enrollment period or don't qualify for an enrollment period at this time.

7. _____ We didn't get the information we requested from you within the timeframe listed in our request.

8. _____ The request was made by someone other than the beneficiary and that individual isn't the beneficiary's authorized representative.

[10. _____ ***MA-PD plans only:*** You are not eligible to enroll in prescription drug coverage at this time.]

[11._____ ***MA-PD plans only:*** You have drug coverage from your employer or union and you told us you don't want to join <MA plan>.]

[12. _____ ***Special needs plans only:*** You are not eligible for this Special Needs Plan because you don't <insert special needs criteria>.]

If <plan name> paid for any of your health care services, then we will bill you for the amount paid.

[Insert if item 3 or 5 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U.S. or if you're incarcerated.*]*

Back to Agenda Back to Item

[Insert if item 7, 8, 9 or 10 is selected: You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.*]*

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you believe any of the checked items are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 8: Model Notice for CMS Rejection of Enrollment

Referenced in section(s): 40.4.2
(Rev. 2, Issued: *August 12*, 2020; Effective/Implementation: 01-01-2021)

Dear <Name of Beneficiary>:

[*If sending in place of combined acknowledgement/confirmation notice, insert the following sentence*: Thank you for your request to enroll in <plan name>.] Medicare has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. _____ You don't have Medicare Part A
2. _____ You don't have Medicare Part B
3. _____ You are unlawfully present in the United States.
4. _____ You are incarcerated and currently reside out of our service area.
5. _____ You attempted to enroll outside of an enrollment period or you don't qualify for an enrollment period at this time.
6. _____ You requested to enroll in a different plan for the same effective date, which canceled your application with <plan name>.

If <plan name> paid for any of your health care services, then we will bill you for the amount paid.

[Insert if item 3 or 5 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U.S. or if you're incarcerated.*]*

[Insert if item 6 is checked: You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.*]*

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these

savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you believe any of the checked items are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 9: Model Notice to Send Out Disenrollment Form (MA-PD enrollee)

Referenced in section(s): 50.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

Attached is the disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <plan name>.

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

What is Extra Help?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

When should I fill out the disenrollment request form?

- You **should** fill out the attached form if you want to change to Original Medicare only and do not want Medicare prescription drug coverage.
- You **shouldn't** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage plan or other Medicare health plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.
- You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.

Until your disenrollment date, you must keep using <plan name> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <plan name>'s network.

How do I submit the disenrollment request?

If you want Original Medicare, as described above, you may fill out the attached form, sign it,

and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can call 1-800-MEDICARE (1-800-633-4227) for information about Medicare plans available in your area. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

What are my Medigap rights?
If you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap policy, also known as Medicare supplemental insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information about trial periods. TTY users should call 1-877-486-2048.

If you need any help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Attachment

Exhibit 9a: Model Notice to Send Out Disenrollment Form (MA-only enrollee)

Referenced in section(s): 50.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

Attached is the disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <plan name>.

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*Dual eligible Special Needs Plans may omit this* paragraph: **What is Extra Help?**
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.]

When should I fill out the disenrollment request form?
You **should** fill out the attached form if you want to change to Original Medicare only and don't want Medicare prescription drug coverage.

You **shouldn't** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage or other Medicare Health Plan. Enrolling in another Medicare plan will automatically disenroll you from <plan name>.

[*MA-only coordinated care plans insert:* You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.]

[*MSA plans insert:* Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

Until your disenrollment date, you must keep using <plan name> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <plan name>'s network.

How do I submit the disenrollment request?
If you want Original Medicare, as described above, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for information about Medicare plans available in your area. TTY users should call 1-877-486-2048.

What are my Medigap rights?
If you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you need any help, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Attachment

Exhibit 10: Model Disenrollment Form

Referenced in section: 10
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

If you request disenrollment, you must continue to get all medical care from <plan name> until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of <plan name>'s network. We will notify you of your effective date after we get this form from you.

Last name: First Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Medicare Number: (Note: may use "Member Number" instead of "Medicare Number")			
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )	

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in <MA plan name> on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your Signature*: _____ Date: _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <plan name> or by Medicare.

If you are the authorized representative, you must provide the following information:

Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Exhibit 10a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Referenced in section: 30.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

- ☐ I am joining a PACE program on (insert date) _____.

- ☐ I am joining employer or union coverage on (insert date) _____.

- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact <plan name> at <phone number> (TTY users should call <TTY number>) to see if you are eligible to disenroll. We are open <insert days and hours of operation>.

Exhibit 11: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in section(s): 50.1, 50.1.4, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <plan name>. You will be disenrolled starting <effective date.> Beginning <effective date>, <plan name> won't cover any health care you get. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans insert:* When coverage from <plan name> ends, your <plan name> prescription drug coverage ends too. **If you don't take any action, you will be covered by Original Medicare beginning <effective date>.** To have new health care coverage and prescription drug coverage on <effective date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare and want Medicare prescription drug coverage, you must join a Medicare prescription drug plan. If you don't enroll in a Medicare prescription drug plan on your own and you have both Medicare and Medicaid, Medicare will enroll you in a Medicare prescription drug plan, unless you tell the plan you don't want to join. If you don't enroll in another Medicare Advantage plan with prescription drug coverage or Medicare prescription drug plan, or if you don't get creditable coverage as good as Medicare prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*MA-only plans insert:* Disenrolling from <plan name> doesn't affect any prescription drug coverage you may have. To have new health care coverage on <effective date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. If you don't take any action, you will be covered by Original Medicare beginning <effective date>.]

[*MSA plans insert the following*: Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

Please be patient. It will take a few weeks for us to process your disenrollment and update Medicare's records. If your doctors need to send Medicare claims, you may want to tell them that you just disenrolled from <plan name> and there may be a short delay in updating your records.

Information About Medigap Rights
If you will be changing to Original Medicare you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health

problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you need any help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

[*Dual eligible Special Needs Plans may omit this* paragraph: Did you know that people with limited incomes may qualify for extra help to pay for their prescription drug costs? If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

Thank you.

Exhibit 11a: Model Notice to Request Information (Disenrollment)

Referenced in section(s): 30, 50.4.2

Dear <Name of Member>:

We received your request to disenroll from <plan name>. However, it is missing information that will help us to determine if we can accept your request. We cannot process your disenrollment without this information.

Please review the checked item(s) below and contact us immediately.

_____ Medicare requires that you sign your written disenrollment request. The request we received from you didn't include a signature. Please call us at the number below to confirm that you want to disenroll from <plan name>.

_____ During certain times of the year, Medicare doesn't let you disenroll unless you meet certain special exceptions, such as if you qualify for extra help with your prescription drug costs. Please call us at the number below to help us determine if you're able to disenroll at this time.

_____ The request we received was from someone other than you and that individual isn't listed as your authorized representative. Please call us at the number below so that we may confirm your request to disenroll.

_____ Other: _____

If you have any questions about the information in this letter or would like to provide us with information to help us process your disenrollment request, you may contact us by telephone or mail:

<plan name>
<mailing address>
<toll free number and days/hours of operation)
<TTY toll-free number>

You may also fax us information at <fax number>.

If we don't get this information, we will have to deny your request to disenroll from our plan.

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week to disenroll by telephone. TTY users should call 1-877-486-2048. If you're receiving coverage through your employer, you should contact your employer instead of calling 1-800-MEDICARE to find out how this affects your retiree benefits.

Thank you.

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Following Receipt of *Daily* Transaction Reply Report (*D*TRR)

Referenced in section(s): 50.1, 50.4.1, 60.3.2

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <MA Plan>. Beginning <effective date,> <plan name> won't cover your health care. If your doctor needs to send Medicare claims, you may want to tell them that there may be a short delay in updating your records since you recently disenrolled from <plan name>.

[*MA-PD plans insert the following*: If your <plan name> premium is being deducted from your Social Security or Railroad Retirement Board benefit, please allow up to 3 months for Social Security or the Railroad Retirement Board to process a refund. If you have not received a refund within 3 months of this letter, you should contact 1-800-MEDICARE.]

[*MSA plans insert the following*: Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

INFORMATION ABOUT MEDIGAP RIGHTS

If you will be changing to Original Medicare you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you think you didn't disenroll from <plan name>, and you want to keep being a member of <plan name>, please call us right away at <phone number> so we can make sure you stay a member of <plan name>. Medicare gives you only 30 days from the date of this letter to contact us. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

[*Dual eligible Special Needs Plans may omit this paragraph*: Did you know that people with limited incomes may qualify for extra help to pay for their prescription drug costs? If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social

Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

Thank you.

Exhibit 12a: Model Notice for MA Organization Denial of Disenrollment

Referenced in section: 50.1.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Beneficiary>:

We recently got your request to disenroll from <plan name>. We cannot accept your request for disenrollment because:

1. _____ You have attempted to make a change outside of an enrollment period or you don't qualify for an enrollment period at this time.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below).

3. _____ We didn't get the information we requested from you within the timeframe listed in our request.

4. _____ The request was made by someone other than the enrollee and that individual isn't the enrollee's authorized representative.

When can I make changes to my coverage?
There are limits to when and how often you can change the way you get Medicare.

- **From October 15 through December 7,** anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]
What is extra help?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local

Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you believe any of the items we checked are wrong, or if you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 12b: Model Notice for CMS Rejection of Disenrollment

Referenced in section: 50.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Beneficiary>:

Medicare has denied your disenrollment from <plan name> due to the reason(s) checked below:

1. _____ You have attempted to make a change outside of an enrollment period or you don't qualify for an enrollment period at this time.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

When can I make changes to my coverage?
There are limits to when and how often you can change the way you get Medicare.

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*Dual-eligible SNPs may omit the following paragraph***:]**
What is extra help?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you believe any of the items we checked are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 12c: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan

Referenced in section: 50.4.1

IMPORTANT INFORMATION ABOUT YOUR UPCOMING DISENROLLMENT FROM YOUR MEDICARE ADVANTAGE PLAN

<Date>

Dear <Name of Member>:

Your state has enrolled you into a new plan that will provide all of your Medicare and Medicaid benefits, including prescription drugs. You should have already gotten a letter from your state telling you about the new plan.

This letter confirms your disenrollment from <MA plan name>. You will continue to get your Medicare benefits from <MA plan name> until <disenrollment effective date>. Beginning <day following disenrollment effective date>, your new plan will cover your health care.

You will be automatically enrolled in your new plan starting <day following disenrollment effective date>, so you don't have to do anything if you want to be a member of this new plan. In a few weeks, you should get a letter from your new plan confirming your enrollment. **There will be no gap in your Medicare and Medicaid coverage** [MA-PD plans insert the following: including your prescription drug coverage].

The letter from your new plan will tell you how to contact them. You can call your new plan with questions about your new coverage or to see if you can still see your current doctors in your new plan. You can also ask for lists of network primary care providers, covered drugs and pharmacies.

If you have questions about your disenrollment from <MA plan name>, please call us at <phone number> (TTY users should call <TTY number>). We are open <days and hours of operation>. If you do not wish to be automatically enrolled in a new plan, call your state or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use a TTY. You can also call 1-800-MEDICARE if you have questions about Medicare or need help with your Medicare options.

Thank you.

Exhibit 13: Model Notice of Disenrollment Due to Death

Referenced in section(s): 50.2.3, 50.4.2, 60.3.1

To the Estate of <Member Name>:

Medicare told us of the death of <Member's Name>. Please accept our condolences.

<Member's name>'s coverage in <plan name> [ended; will end] as of <effective date>. If plan premiums were paid for any month after <effective date>, we will issue a refund to the Estate within 30 days of this letter.

[*MA-PD plans insert the following*: If the <plan name> premium is being deducted from <Member Name>'s Social Security or Railroad Retirement Board benefit, please allow up to 3 months for Social Security or the Railroad Retirement Board to process a refund. If the estate has not received a refund within 3 months of this letter, a representative of the estate should contact 1-800-MEDICARE anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*MSA plans insert the following*: Please note that the Estate has to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time of enrollment. The amount owed is based on the number of whole months left in the year after the date of death.]

If this information is wrong, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 14: Model Notice of Disenrollment Due to Loss of Medicare Part A and/or Part B

Referenced in section(s): 50.2.2, 50.4.2, 60.3.1

Dear <Name of Member>:

Medicare has told us that you [will] no longer have Medicare Part <insert A and/or B, as appropriate>. You need to have coverage under both Medicare Part A and Part B to remain enrolled in a Medicare Advantage plan. Therefore, your membership in <plan name> [ended; will end] on <date>. If this information is wrong, and you want to stay a member of our plan, please contact us. Also, if you haven't already done so, please contact your local Social Security office to have their records corrected.

[*MA-PD plans insert*: When coverage from <plan name> [ends; ended] on <date>, your Medicare prescription drug coverage [will end; ended] too. If you still have either Medicare Part A or Medicare Part B you are eligible for Medicare prescription drug coverage. To get Medicare prescription drug coverage, you must enroll in a Medicare prescription drug plan such as a Medicare Advantage Plan with prescription drug coverage or a Medicare Prescription Drug Plan. If you are eligible to join a Medicare prescription drug plan but don't join, and you don't have other drug coverage that is at least as good as Medicare's, you may have to pay a late enrollment penalty if you join later. This means you pay a higher premium for as long as you have Medicare prescription drug coverage. Remember, Medicare limits how and when you can make changes to your coverage. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 15: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

Medicare records incorrectly show you as deceased.

If you haven't already done so, please go to your local Social Security Office and ask them to correct your records. Please send us written proof at <address> after you do this. When we get this proof, we will share it with Medicare.

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. MA plans may insert "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.] If you have any questions or need help, please call us at < phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 16: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination

Referenced in section(s): 60.3, 60.3.1

Dear < Name of Member>:

On <date of request> you told us that your enrollment in Medicare was ended in error and that you want to stay a member of <plan name>.

[*Organizations that are able to verify current Medicare entitlement may omit the following*:
To do this, please complete the following three steps no later than <insert date: 60 days from date of disenrollment notice>:

1. Contact Social Security at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records TTY users should call 1-800-325-0778.

2. Ask Social Security to give you a letter that says they have fixed your records.

3. Send the letter from Social Security to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we get this letter, we will tell the Medicare to correct its records.]

[*Organizations that are able to verify current Medicare entitlement insert*: Social Security corrected the error. We will tell Medicare to correct its records.]

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. MA plans may insert "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.]

[*Organizations that are able to verify current Medicare entitlement omit the following*:
If we find out that you don't have Medicare Part <insert "A" and/or "B" as appropriate>, or if we don't get proof that you have Medicare by <insert date: 60 days from date of disenrollment notice>, you will have to pay for any service you got after <disenrollment date>.]

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error

Referenced in section(s): 60.3, 60.3.3

Dear <Name of Member>:

Thank you for letting us know that you want to remain a member of <plan/sponsor name> after we mistakenly [*select one based on the circumstance:* disenrolled you from/cancelled your enrollment in] our plan. [*Insert brief summary of the plan error that caused the disenrollment.]* We apologize for the inconvenience. We have changed our records to show that you are still a member of <plan/sponsor name>. You should keep seeing your <plan name> [*insert appropriate term*: <primary care physician, physicians, doctors, providers, pharmacies, etc.] for your health care.

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 18: Model Notice to Close Out Request for Reinstatement

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

We cannot process your request to be in <plan name> again because we haven't gotten the information we requested. As discussed in our letter of <date of letter> you must send us this information by <date placed on notice in Exhibit 16> to remain a member of our plan.

You were no longer a member of our plan as of <effective date>. If <plan name> paid for any services after this disenrollment date, we will have to bill you for those services.

If you have any questions, please call <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage of Optional Supplemental Benefit(s)

Referenced in section: 50.3.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

Our records show that we haven't gotten payment for your plan premium as of <premium due date>.

[*MA organizations who will disenroll all members (and not use the downgrade option) use the following sentences:* If we don't get payment by <date grace period expires>, we will have to disenroll you from <plan name>, effective <disenrollment date>. After <disenrollment date> you will be covered by Original Medicare instead of <plan name>.]

[*Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent disenrollment.*]

[*MA organizations who will reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefit(s) use the following sentences:* If we don't get payment by <date grace period expires>, we will make some changes to your membership in <plan name> that will reduce the amount of health care coverage you have in <plan name>. This means that <describe lower level of benefits, e.g., routine dental care will not be covered> beginning <date>.]

[*Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent the downgrade.*]

[*Insert if applicable in state where member resides:* If you get medical assistance (Medicaid) from your State (including paying your premiums, deductibles, or coinsurance), you should check with your State Medicaid Agency to find out if they have been paying for, or have stopped paying for, your plan premium. If you are no longer eligible for assistance from Medicaid, you may have a special temporary right to buy a Medigap policy if you voluntarily disenroll from our plan. If you have questions about Medigap policies, you should contact your State Health Insurance Program, <name of SHIP>, at <SHIP phone number(s)> to get more information.]

If you wish to disenroll from <plan name> and change to Original Medicare now, you should do one of these two things:

1. Send us a written request at <MA Plan address>.

2. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Remember, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you paid the premium recently and you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 20: Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

Referenced in section(s): 50.3.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

On <date> we sent you a letter that said your plan premium was overdue. The letter said that if we didn't get payment from you, we would disenroll you from <plan name>. Since we didn't get that payment, we asked Medicare to disenroll you from <plan name> beginning <effective date>. You will be covered by Original Medicare beginning <effective date>.

[***MA PFFS do not include this paragraph:*** Please note that until <disenrollment effective date>, you must keep using <plan name> doctors except for emergency or urgently needed care or out-of-area dialysis services. After that date, you can see any doctor through Original Medicare, unless you join a Medicare Advantage plan or another Medicare health plan.]

What if I think there's been a mistake?
If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <*insert* "Member Handbook" *or* "Evidence of Coverage," *as appropriate*>.

I had an emergency that kept me from sending my payment. What can I do?
You can ask us to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed premium amounts within three (3) months of your disenrollment in order to get your coverage back. To ask us to review this decision, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. You must make your request no later than <insert the date that is 60 calendar days after the disenrollment effective date>.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[***MA-PD plans insert:*** Please remember, if you don't have other creditable coverage (prescription drug coverage expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

For more information:

If you have any questions or if you have recently sent us a payment, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 21: Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment

Referenced in section(s): 50.3.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <plan name> because you didn't pay your plan premium. Your disenrollment begins <effective date>. You are now enrolled in Original Medicare.

What if I think there's been a mistake?
If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <*insert* "Member Handbook" *or* "Evidence of Coverage," *as appropriate*>.

I had an emergency that kept me from sending my payment. What can I do?
You can ask us to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed premium amounts within three (3) months of your disenrollment in order to get your coverage back. To ask us to review this decision, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. You must make your request no later than <insert the date that is 60 calendar days after the disenrollment effective date>.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for

these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

For more information:
If you have any questions, or need help, please call <plan name> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 21a: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount

Referenced in section: 50.2.6
(Rev. 2, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

Important – You have been disenrolled from your Medicare Advantage Prescription Drug Plan

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <MA-PD plan name> because you didn't pay the extra amount (called the Part D-Income Related Monthly Adjustment Amount or Part D-IRMAA). As of <effective date>, you will no longer have coverage through <MA-PD plan name>. Your Medicare prescription drug coverage will also end on the same date. Since the disenrollment has already processed, you can't pay the owed amounts now to keep your Part D coverage.

Before you were disenrolled, Medicare (or the Railroad Retirement Board) sent you notices that showed the amount that you owed and provided information on how to pay this amount. If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, not by <plan name>.

What if I think there's been a mistake?
If you paid the Part D-IRMAA or think that there has been a mistake, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

I had an emergency that kept me from sending my Part D-IRMAA payment. What can I do?
You can ask Medicare to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If Medicare approves your request, you will have to pay all Part DIRMAA and plan premium amounts owed within three (3) months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

Please remember, if you don't request reinstatement within 60 days and pay all owed amounts within 3 months, you will not get your coverage back and will have to wait for another opportunity to enroll. If you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late

enrollment penalty in addition to the monthly Part D-IRMAA and plan premium, if you enroll in Medicare prescription drug coverage in the future.

When can I get Part D coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 of each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Who can I call to get more information?
You can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week if you have questions about your disenrollment because you didn't pay the Part D-IRMAA. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions about your plan's premium. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 22: Model Notice on Failure to Pay Optional Supplemental Benefit Premiums - Notice of Reduction in Coverage of Optional Supplemental Benefit(s) Within the Same Plan (PBP)

Referenced in section(s): 50.3.1
(Rev. *2*, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

Dear <Name of Member>:

We recently sent you a letter dated <date> that said your plan premium was overdue. The letter said that if we didn't get payment from you, we would have to make some changes in your membership in <plan name>. Our records show that we did not get payment from you as of <date>. Therefore, we have reduced your coverage in <plan name>, beginning <effective date>.

<Explain in simple terms lower level of benefits, e.g., routine dental care won't be covered>

You have the right to ask us to reconsider this change through the grievance procedure written in your <insert "Member Handbook" or "Evidence of Coverage", as appropriate>.

Remember, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7,** anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*Dual-eligible SNPs may omit the following paragraph*:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 22a: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement

Referenced in section: 60.3.4
(Rev. 2, Issued: *August 12*, 20*20*; Effective/Implementation: 01-01-20*21*)

Dear <Name of Member>:

Medicare has notified us that you received a favorable decision on your request for reinstatement into <plan name>. Our records show that we haven't gotten payment for your plan premium as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of <enter amount owed> no later than <date 3 months from the effective date of disenrollment>.

This amount is due in addition to the amounts you owe <Medicare or RRB> for your Part D-IRMAA. You do not pay us your owed Part D-IRMAA amounts. <Medicare or RRB> will send you a letter regarding the amount you owe and how you can pay. You must pay <Medicare or RRB> this amount by <date 3 months from the effective date of disenrollment> to be reinstated.

[*MA organizations that include a payment coupon with the letter, insert the following sentences:* You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[*MA organizations that do not include a payment coupon with the letter, insert the following sentences:* You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and [*insert* one: member number/billing number/ID number] on the check.]

If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>. You will be covered by Original Medicare instead of <plan name>.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may

have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

For more information:
If you have any questions regarding the plan premium amount you owe and how you can pay, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 22b: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Plan Premium Amount Due for Reinstatement

Referenced in section: 60.3.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been approved. Our records show that we haven't gotten payment for your plan premium as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of **<enter amount owed> no later than <date 3 months from the effective date of disenrollment>**.

[*MA organizations that include a payment coupon with the letter, insert the following sentences:* You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[*MA organizations that do not include a payment coupon with the letter, insert the following sentences:* You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and [*insert one:* member number/billing number/ID number] on the check.]

If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>. You will be covered by Original Medicare instead of <plan name>.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[Dual-eligible SNPs may omit the following paragraph:
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for

these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213.
TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.*]*

For more information:
If you have any questions regarding the plan premium amount you owe and how you can pay, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 22c: Model Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums

Referenced in section: 60.3.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been denied. This is because [I*nsert one of the following*: your request doesn't meet the criteria for reinstatement OR [*Insert if unable to make a decision based on the original request and unable to reach beneficiary*: we were not able to reach you to get the information needed to see if your circumstances meet the criteria for reinstatement.] This means you'll remain disenrolled from your plan. This decision is final and can't be appealed.

You are still responsible for paying the plan premiums you owed at the time you were disenrolled.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.]

For more information:
If you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 22d: Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment

Referenced in section: 60.3.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>
<Beneficiary full name>
<Address>
<City, State Zip>

Dear <Beneficiary Name>:

We recently sent you a letter letting you know that we gave you a favorable decision on your request to get your coverage back.

The letter told you that in order to be reinstated into <plan name>, you had to pay all plan premiums you owe by <insert date 3 months after disenrollment effective date>. The amount owed was <$ insert total premium amount owed>. The letter also told you that if we didn't get full payment by the deadline, you would stay disenrolled [*insert if Part D coverage included in plan*: and you would not have Medicare prescription drug coverage].

Your Payment Wasn't Received on Time

Because you didn't pay the full amount you owe by the deadline, you will stay disenrolled from your Medicare plan. This decision is final and can't be appealed.

You are still responsible for paying the plan premiums you owed at the time you were disenrolled.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.]

For more information:
If you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 22e: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement)

Referenced in section: 60.3.4.1

<Member # >

[*Insert RxID, RxGroup, RxBin and RxPCN if individual is being reinstated into Part D coverage*]

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been approved. Our records show that we received the plan premium you needed to pay in order for your coverage to be reinstated.

We have updated our records to show that you are enrolled in <plan name> with no break in coverage. We will ask Medicare to correct its records to show the same.

You should keep using your <plan name> primary care physician for your health care. (*If PCP not applicable, terms such as "physicians" or "doctors" or "providers" may be used instead of "primary care physician."*)

If you have any questions about your plan premium and how you can pay, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you for your continued membership in <plan name>.

Exhibit 23: Model Notices for Closing Enrollment

Referenced in section(s): 30.8.1

Model A: Closing Enrollment for Partial Month(s)

<MA organization> PUBLIC NOTICE

As of <date> <MA organization> will no longer offer continuous open enrollment under its Medicare Advantage contract with Medicare for <plan name> in <service area>.

Instead, <MA organization> will offer open enrollment for all eligible individuals from the <insert date> to the <insert date> of each month.

<MA organization> will continue to accept enrollments into <plan name> during an entire month from people who meet certain special exceptions, such as if someone moves out of the plan's service area or qualifies for extra help with prescription drug costs.

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals from October 15 through December 7.

Current members of <plan name> aren't affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call<TTY number>.

Thank you.

Model B: Closing Enrollment for Whole Month(s)

<MA organization> PUBLIC NOTICE
As of <date> <MA organization> will no longer offer open enrollment under its Medicare Advantage contract with Medicare for <plan name> in <service area>.

However, <MA organization> will continue to accept enrollments into <plan name> from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals during the Annual Election Period from October 15 through December 7.

Current members of <plan name> aren't affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. Thank you.

Model C: Closing Enrollment for Capacity Reasons

<MA organization> PUBLIC NOTICE

As of <date>, <MA organization> will no longer accept enrollment under its Medicare Advantage contract with Medicare for <plan name> in <insert service area>.

<MA organization> is limiting enrollment in <plan name> so plan members have greater access to providers and services.

Current members of <plan name> aren't affected by this change. Also, individuals who are enrolled in other <MA organization> plans may still be able to enroll in <plan name> when they become eligible for Medicare.

For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 24: Model Notice for Medigap Rights Per Special Election Period

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled from <plan name> effective <date> and returned to Original Medicare because of the special circumstances indicated below:

_____ You permanently moved.

_____ You get help from the Medicaid program.

_____ You wanted to use certain Medigap protections while in your trial period.

_____ Other circumstances defined as eligible for a Special Election Period.

Please save this letter as proof of your Medigap rights.

[**Information about Medigap rights**
Since you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap (Medicare supplement insurance) policy, even if you have health problems. For example, if you are age 65 or older, and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. Your State may have laws that provide more Medigap protections. If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.]

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 25: Acknowledgement of Request to Cancel Enrollment

Referenced in section(s): 60.2.1
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <name of applicant>:

As requested, we have cancelled your request to enroll with <plan name>.

Please be patient. It may take up to 45 days for Medicare to update your records. If you are in Original Medicare, you may want to tell your doctors that if they need to submit Medicare claims, there may be a short delay in updating your records.

Important: If you were enrolled in another Medicare Advantage plan or Medicare prescription drug plan before enrolling with <plan name>, you should be automatically enrolled back into that plan.

If you don't receive an enrollment acknowledgement letter from your previous plan within two (2) weeks of receiving this letter, please contact them to confirm your enrollment. They may request a copy of this letter for their records.

Please remember that if you don't have or get Medicare prescription drug coverage or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

[*Dual-eligible SNPs may omit the following paragraph*:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you have any questions, please contact <plan name> at <number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 25a - Model Acknowledgment of Reinstatement

Dear <member name>:

Please be sure to keep a copy of this letter for your records.

Medicare has enrolled you back in <plan name> with no break in coverage as of <effective date>.

[*If PCP not applicable, omit following sentence. Terms such as "physicians" or "doctors" or "providers" may be used instead of "primary care physician":* You should keep using your <plan name> primary care physician for your health care.]

[*Insert one of the following sentences depending on plan policy:* We will be sending you a new membership card and other important documents for <plan name>. *or* You can continue using the <plan name> membership card that you currently have. *or* If you no longer have your membership card, contact us at the number below to get a new card.]

[*Insert information regarding plan premiums required to maintain enrollment, or use the following language:* The monthly premium for <plan name> is <monthly premium amount>. You must pay this premium amount each month to remain enrolled in our plan. For more information regarding our disenrollment policy for non-payment of plan premiums, please see our policy written in your <insert "Member Handbook" or "Evidence of Coverage", as appropriate>.]

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 25b: Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)

Referenced in section(s): 60.2.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear <name of applicant>:

Medicare has told us that you have canceled your enrollment in <plan name> effective <insert date of enrollment that was canceled>. If this information is wrong, and you want to stay a member of our plan, please contact us.

Please remember that if you don't have or get Medicare prescription drug coverage or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you have any questions, please contact <plan name> at <number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

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Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

Referenced in section(s): 60.2.2

Dear <name of member>:

As requested, we have cancelled your disenrollment with <plan name>. [*If PCP not applicable, omit following sentence. Terms such as "physicians" or "doctors" or "providers" may be used instead of "primary care physician":* You should keep using your <plan name> primary care physician for your health care.] Thank you for your continued membership in <plan name>.

IMPORTANT: If you have also enrolled in another Medicare Advantage plan or Medicare Cost plan or Medicare Prescription Drug Plan, you may appear on their records as being enrolled. If you want to stay enrolled in <plan name>, you will need to notify the other Medicare plan that you are canceling enrollment in their plan before that enrollment takes effect. They may request you write them a letter for their records.

If you have any questions, please contact <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 27: MA Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in MA-PD Plan

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. [*Insert for those with retroactive effective dates:* To make sure that you don't lose a day of your drug coverage,] [*Insert for those with prospective effective dates:* To make sure you have prescription drug coverage,] Medicare has asked us to enroll you in our <MA-PD plan name> that includes Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

Starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <plan name> doctor(s). You will need to pay our copayments when you get health care. [*Optional:* This letter is proof of insurance that you should show during your doctor appointments.] [*Optional*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What are my costs in this plan?
With this Medicare prescription drug coverage, you will pay no more than:

- $0 for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by the plan.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

[*Include cost of premium less low-income premium subsidy amount, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.*]

What do I need to know about getting health care services?
[***MA PPO and PFFS plans do not use the following paragraph:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care from a non-<new plan name> doctor without prior authorization, you will have to pay for the health care yourself.]

[***MA PPO plans use the following paragraph*:** Beginning <effective date>, you will get your health care as provided in your <*insert either "Member handbook" or "Evidence of Coverage"*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[***MA PFFS plans use the following paragraph:*** Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. <new plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital doesn't have to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

What if Medicaid used to pay for my prescription drugs?
Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <new plan name>.

What if I have other prescription drug coverage?
If you now have drug coverage through an employer or union plan, joining a Medicare drug plan may NOT be right for you. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family current coverage. You may not need to join a Medicare drug plan. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy.

What if I want to join another plan?
You aren't required to be in our Medicare prescription drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare prescription drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

What if I don't want Medicare prescription drug coverage?
If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> within 10 days of the date on this letter. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 27a: MA-PFFS Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. To make sure you have prescription drug coverage. Medicare has asked us to enroll you in our <PDP name> that provides Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

How does this plan work?
Starting <effective date>, all of your health care will continue to be covered under your <current MA-only plan name> and your prescription drug coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan> won't change. **[Optional:** You will be sent a membership card along with more detailed information about your prescription drug coverage in the next several days. Until you get your prescription drug card, you can use this letter to buy your prescriptions.]

With the addition of this Medicare prescription drug coverage, you will pay no more than:

- $0 for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by the plan.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

There will be no changes to your premium, medical benefits or member copayments under the <current MA-only plan name>.

What if Medicaid used to pay for my prescription drugs?
Remember, Medicaid won't pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

What if I have other prescription drug coverage?
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I paid for drugs before my new coverage starts?
If you filled any covered prescriptions before <effective date>, you might be able to get back part of what the prescriptions cost if you were eligible for Medicare and Medicaid but not enrolled in a Medicare drug plan. Call Medicare's Limited Income NET program at 1-800-783-1307. TTY users should call 711. You can also visit www.humana.com/pharmacists.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?
You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> within 10 days of the date on this letter. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment into MA-PD plan

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare has asked us to enroll you in our <MA-PD plan name> that offers Medicare prescription drug coverage beginning <effective date>, unless you tell us you don't want to join our plan.

[***MA PPO and PFFS plans do not use the following paragraph:*** Starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <MA-PD plan name> doctor(s). You will need to pay our copayments when you get health care.]

[*Optional:* This letter is proof of insurance that you should show during your doctor's appointments until you get your member card from us**.**] [*Optional*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What are my costs in this plan?
With Medicare prescription drug coverage, you will pay no more than:

- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by our plan.

[*Include cost of premium less amount of premium assistance for which the member is eligible, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.*]

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

What do I need to know about getting health care services?
[***MA PPO and PFFS plans do not use the following paragraph:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care from a non-<MA-PD plan name> doctor without prior authorization, you will have to pay for the health care yourself.]

[***MA PPO plans use the following paragraph:*** Beginning <effective date>, you will get your health care as provided in your <*insert either "Member handbook" or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[***MA PFFS plans use the following paragraph:*** Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. <MA-PFFS plan name>, a Medicare Advantage Private Fee-for-Service Plan, works differently than Original Medicare. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

What if I have other prescription drug coverage?
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?
You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> before <effective date>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 28a: MA Model Notice to Inform Member of Facilitated Enrollment into PDP

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs . To make sure you have prescription drug coverage, Medicare has asked us to enroll you in our <name of PDP> that provides Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

Starting <effective date>, all of your health care, will continue to be covered under your <current MA-only plan name>, and your pharmacy coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan name> won't change. [*Optional:* You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]

With the addition of this Medicare prescription drug coverage, you will pay no more than:

- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

There will be no changes to your premium, medical benefits or member copayments under <current MA-only plan name>.

What if I have other prescription drug coverage?
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include

coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I paid for drugs before my new coverage starts?
If you filled any covered prescriptions before <effective date>, you might be able to get back part of what the prescriptions cost if you were eligible for Medicare and Medicaid but not enrolled in a Medicare drug plan. Call Medicare's Limited Income NET program at 1-800-783-1307. TTY users should call 711. You can also visit www.humana.com/pharmacists.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?
You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> before <effective date>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 29: Acknowledgement of Request to Opt Out of Auto/Facilitated Enrollment

Referenced in section(s): 40.1.5
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <name of member>:

As requested, we have processed your request to decline (opt out of) Medicare prescription drug coverage. You will continue to be a member of <plan name> that doesn't offer Medicare prescription drug coverage.

If you have Medicaid drug coverage, it won't pay for your prescription drugs.

Remember, even if you don't use a lot of prescription drugs now, you still should consider joining a Medicare prescription drug plan. As we age, most people need prescription drugs to stay healthy.

From October 15 through December 7, you can join, switch or drop a Medicare health or drug plan for the following year. You can join, switch or leave a plan at other times while you qualify for (or lose) Extra Help paying for prescription drug costs.

If you change your mind and would like to join, you can call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 30: Model Notice for Enrollment Status Update

(For use with Transaction Reply Codes (TRC) from User Interface (UI) changes)

Referenced in section: 60.7

[Member #]

Dear <Name of Member>:

Your enrollment in <Name of Plan> has been updated.

[*Insert one or more of the following, including sufficient detail to describe the specific enrollment change:*

- You have been enrolled in <name of plan>. Your coverage will start on <*insert start date*> and will end on <*insert end date*>. [*Insert information about premiums, if applicable, and how to access coverage, etc*.].

- Your enrollment in <*name of plan/old PBP*> has been changed to <name of plan/new PBP>. Your coverage in <*name of plan/new PBP*> will start on <*date*>. [*Insert information on premium differences (if any), cost sharing information, and other details the individual will need to ensure past and future coverage is clear*]

- Your enrollment in <*Name of Plan*> has been changed to start on an earlier date. Your coverage will start <*date*>. [*Include information about premiums, coverage, and how to get refunded for prescriptions purchased in the period of retroactive coverage.*]

- Your enrollment in <*Name of Plan*> has been changed to start on a later date. Your coverage with <*Name of Plan*> will start on < *date*>. [*Insert information about refunding premium, where applicable, and impact to paid claims*]

- Your enrollment in <*Name of Plan*> [*ended, will end*] on < *date*>. This means you [*don't, won't*] have coverage from <*Name of Plan*> after <*date*>. [*Insert appropriate descriptive information, such as premium owed if the date has moved forward, or premium refunds if the date has moved back, and impact on paid claims or how to submit claims, as applicable*]

- Your enrollment in <*Name of Plan*> has been cancelled. This means that you don't have coverage from <*Name of Plan*>. [*Insert information about refund of premium, if applicable, and impact to any paid claims*]

[*Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary*]

[*Insert if enrolling in a PFFS plan:* <Name of Plan>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital isn't

required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*Dual-eligible SNPs may omit the following paragraph*:]
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Call <*toll-free number*> <*days and hours of operation*> to get more information. TTY users should call <*toll-free TTY number*>.

Thank you.

Exhibit 31: Model Employer/Union Sponsored MA Plan Group Enrollment Mechanism Notice

Dear <name>

<Name of Employer/Union> is enrolling you in <plan name > as your retiree health benefit plan beginning <effective date>, unless you tell us by <insert date no less than 21 days from date of notice> that you don't want to join our plan. <Plan name> is a Medicare Advantage plan. This enrollment will automatically cancel your enrollment in a different Medicare Advantage plan or a Medicare Prescription Drug (Part D) plan. Please call us if you think you might be enrolled in a different Medicare Advantage plan or a Medicare Prescription Drug plan.

What do I need to know as a member of <plan name>?
This mailing includes important information about this plan and the coverage it offers, including a summary of benefits document. Please review this information carefully. If you want to be enrolled in this Medicare health plan, you don't have to do anything, and your enrollment will automatically begin on <effective date>.

Once you are a member of <Plan Name>, you have the right to appeal plan decisions about payment or services if you disagree. Read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when you get it to know which rules you must follow to get coverage with this Medicare Advantage Plan. Enrollment in this plan is generally for the entire year.

[***MA PFFS do not include the following paragraph:*** Beginning on the date <plan name> coverage begins, you must get all of your health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR SERVICES.]**

You will need to keep Medicare Parts A and B as <Plan Name> is a Medicare Advantage Plan. You can be in only one Medicare Advantage Plan at a time. It is your responsibility to inform <Plan Name> of any prescription drug coverage that you have or may get in the future.

By joining this Medicare health plan, you acknowledge that the Medicare health plan will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <plan name> will release your information [***MA-PD plans insert:*** including your prescription drug purchase history] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

What happens if I don't join <plan name>?
You aren't required to be enrolled in this plan. <insert information about other group sponsored plan options, if there are any>. You can also decide to join a different Medicare plan. Call 1-800-MEDICARE for help in learning how. However, if you decide not to be enrolled <insert

consequences for opting out of group plan, like that you cannot return, or that other benefits are impacted>. To request not to be enrolled by this process <insert clear instruction for opting out including telephone numbers and times of operation where those numbers will be answered>.

What if I want to leave <Plan Name>?
You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Plan Name>.

<Plan Name> serves a specific service area. If you move out of the area that <Plan Name> serves, you need to notify the plan so you can disenroll and find a new plan in your new area.

[***MA-only plans insert the following, unless the employer/union provides other creditable coverage*:**
Remember that if you leave this plan and don't have creditable prescription drug coverage (as good as Medicare's prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

Thank you.

Attachment

Exhibit 32: Model Notice for Loss of Special Needs Status

Referenced in section: 50.2.5
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

<*Insert plan or organization name*> must disenroll a member from <*Insert plan name*> if a member doesn't <*describe special needs status*> and doesn't reestablish <*describe required special needs status*> prior to the expiration <*insert length of period of deemed continued eligibility* >.

Why am I receiving this notice?

Our records indicate that you no longer <*describe special needs status that individual has lost*>. To be a member of <plan name>, you must <*describe required special needs status*>.

How long will I continue to receive coverage?

<Plan name> will continue to cover your Medicare benefits until <*insert end date for period of deemed continued eligibility*>. You have <*insert length of period of deemed continued eligibility*> to re-qualify for our plan.

When will coverage end?

If, at the end of <*insert length of period of deemed continued eligibility*>, you haven't <*describe special needs criteria that must be met*> and you haven't enrolled in a different plan, we will disenroll you and you will be covered by Original Medicare beginning <*insert end date for period of deemed continued eligibility*>.

What do I do if my coverage ends?

When coverage from <plan name> ends, your Medicare prescription drug coverage ends too. To have new health care coverage and prescription drug coverage after <date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare coverage, to get Medicare prescription drug coverage you must join a Medicare prescription drug plan. Please remember, if you disenroll from <plan name> and don't have or get other creditable prescription drug coverage (as good as Medicare prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

When can I join another plan?

Because you are no longer eligible for our plan, Medicare will give you a special one-time opportunity to change to a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity begins now and ends when you enroll in a different plan or on <*insert date three months after the expiration of the period of deemed continued eligibility*>, whichever is earlier. If you don't take any action, <plan name> will continue to cover your Medicare benefits until <*insert end date for period of deemed continued eligibility*>.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7,** anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*Dual-eligible SNPs may omit the following paragraph*:]
What is extra help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

What if I don't agree with this decision or if I have questions?

If this information is wrong and you continue to be eligible for <plan name> or if you believe you have already re-qualified for our plan and you want to stay a member of our plan, please contact us immediately at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 33: Model Notice for Loss of SNP Status - Notification of Involuntary Disenrollment

Referenced in section(s): 50.2.5
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

On <date> we sent you a letter that said you no longer *<describe special needs status that individual has lost>*. The letter said that if you didn't *<describe special needs criteria that must be met>*, we would disenroll you and you would be covered by Original Medicare beginning *<insert end date for period of deemed continued eligibility>*.

Why am I receiving this notice?
According to our records, you remain ineligible for <plan name>. Therefore, we asked Medicare to disenroll you from <plan name> beginning <date>.

What if I don't agree with this decision?

You have the right to ask us to reconsider this decision through the grievance process described in your [*insert* "Member Handbook" or "Evidence of Coverage", *as appropriate*].

What happens next?

Due to your disenrollment from <plan name>, you will be covered by Original Medicare, beginning <effective date> unless you take action.

When can I join another plan?

As described in our earlier letter, you have a special one-time opportunity to enroll in a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity will end when you enroll in a different plan or on *<insert date three months after the expiration of the period of deemed continued eligibility>*, whichever is earlier.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.

- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you

move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*Dual-eligible SNPs may omit the following two paragraphs*:]
What is extra help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

Why is it important to find new drug coverage?

Please remember, if you don't enroll in another Medicare Advantage Plan with prescription drug coverage or a Medicare Prescription Drug Plan or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Information About Medigap Rights

You might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 34: MA Model Notice to Research Potential Out of Area Status

Referenced in section: 50.2.1.3

<Date>
<Member ID>

Dear <member name>:

We have recently received information that your address may have changed and that you may not live in the service area of <plan name>. **If you don't contact us to verify your address, you will be disenrolled from <plan name> effective <disenrollment effective date>.**

It is important that you contact us to verify your permanent address. You may use this form and return it to us in the enclosed envelope or you may call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Please note that your permanent address must be inside our service area in order for you to be a member of <plan name>. You may request that we send mail to you at another address outside of our service area. You may also temporarily reside for up to [*insert either* "six" *or the length of the plan's visitor traveler program (if any)*] months outside our service area and remain a member of <plan name>. But if you permanently move outside our service area or if you temporarily live outside our service area for more than six months in a row, we must disenroll you from <plan name>. You will have an opportunity to enroll in a plan that serves the area where you now live.

Your Permanent Address
Please tell us the permanent address where you live. Do not use a post office box.

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number:_____ _____

Your Temporary Address
If you are currently living somewhere other than your permanent address, please provide the address. Do not use a post office box. (You may skip this section if you are living at your permanent address.)

Street:_____
City, State, ZIP:_____
County:_____
Current Phone Number:_____
When did you begin living at this address?_____

When do you expect to return to your permanent address?_____

Your Mailing Address

If the address that you want us to use to send information to you is different than your permanent address, please provide it below. (You may skip this section if your mailing address is the same as your permanent address that you provided.)

Street or P.O. Box: _____
City, State, ZIP: _____
County: _____

If you have moved and have not notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

If you have any questions or need help, please call us at <customer service phone number>.

Thank you.

Exhibit 35: MA Model Notice for Disenrollment Due to Out of Area Status (No Response to Request for Address Verification)

Referenced in section: 50.2.1.3
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>
<Member ID>

Dear <member name>:

On <*date of notice requesting address verification*> we asked you to contact us so that we could determine whether you had moved out of the [*Optional:* Parent Organization Name] <plan name> service area. As we explained in our earlier letter, in order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to [*insert either* "six" *or the length of the plan's visitor traveler program (if any)*] consecutive months.

Our records show that you have not responded to our earlier letter. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.**

Beginning <effective date>, <plan name> won't cover any health care you get. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans add the following:* When your coverage from <plan name> ends, your Medicare prescription drug coverage ends too. Beginning <effective date>, <plan name> also won't cover any prescriptions you get. You won't have any prescription drug coverage beginning <effective date> unless you have enrolled in another prescription drug plan.]

What if I disagree with this decision?
You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?
You may have up to two months to join a new Medicare Advantage Plan or a Medicare prescription drug plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don't enroll in a new plan right now?
If you don't enroll in a Medicare Advantage Plan during this special two-month period, you may have to wait to enroll in a new plan. You can join or change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally you can't make changes at other times except in

certain situations, such as you want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help paying for prescription drug costs.

[*MA-PD plans insert*: **What happens if I don't enroll in another Medicare Prescription Drug Plan?**
Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

What if my premium was being deducted from my Social Security benefit check?
If your plan premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[*Dual-eligible SNPs may omit the following paragraph*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

What should I do if I've moved?
If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?
If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 36: MA Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)

Referenced in section: 50.2.1.3
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>
<Member ID>

Dear <member name>:
Thank you for informing us of your recent change of permanent address. Your permanent address is now outside the <plan name> service area. In order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to [*insert either* "six" *or the length of the plan's visitor traveler program (if any)*] consecutive months. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.**

Beginning <effective date>, <plan name> won't cover any health care you receive. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans add the following:* When your coverage from <plan name> ends, your Medicare prescription drug coverage ends too. Beginning <effective date>, <plan name> also won't cover any prescriptions you get. To have new prescription drug coverage after <date>, you need to join a new Medicare Advantage plan with prescription drug coverage or join a Medicare prescription drug plan.]

What if I disagree with this decision?
You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?
You may have up to two months to join a new Medicare Advantage Plan or Medicare prescription drug plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don't enroll in a new plan right now?
If you don't enroll in a Medicare Advantage Plan during this special two-month period, you may have to wait to enroll in a new plan. You can join or change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally you can't make changes at other times except in certain situations, such as you want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help paying for prescription drug costs.

[*MA-PD plans insert*: **What happens if I don't enroll in another Medicare Prescription Drug Plan?**
Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

What if my premium was being deducted from my Social Security benefit check?
If your plan premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE.

[*Dual-eligible SNPs may omit the following paragraph*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

What should I do if I've moved?
If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?
If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 37: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration

Referenced in section: 50.2
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <plan name> because its records show that you are incarcerated. As of <effective date>, you no longer have coverage through <plan name>. [*MA-PD plans insert:* Your Medicare prescription drug coverage ended on the same date.] You will have Original Medicare; however, Medicare generally doesn't pay for your hospital or medical bills if you're incarcerated.

If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, based on information from SSA, not by <plan name>.

What if I think there's been a mistake?
If you aren't incarcerated or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

What happens to my Medicare and Part D coverage?
While you are incarcerated, you are not eligible to enroll in a Medicare health or Part D plan. However, once you are released and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. *This opportunity begins the month you are released and lasts for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after your release, you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

Who can I call to get more information?
You can call Social Security at 1-800-772-1213, if you have questions about your incarcerated status. TTY users should call 1-800-325-0778. If you have questions about your Medicare

coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 38: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence

Referenced in section: 50.2.1, 50.2.7
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear <member name>:

Medicare has disenrolled you from <plan name> because the Social Security Administration (SSA) reported that you are not lawfully present in the United States. As of <effective date>, you no longer have coverage through <plan name>. [MA-PD insert: Your Medicare prescription drug coverage ends on this date.] You will have Original Medicare; however, Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S.

If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, based on information from SSA, not by <plan name>.

What if I think there's been a mistake?
If you aren't unlawfully present in the U.S. or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

What happens to my Medicare and Part D coverage?
While you are unlawfully present in the United States, you are not eligible to receive any coverage in the Medicare program. This includes coverage through Original Medicare, a Medicare health plan or Medicare prescription drug coverage.

If you become lawfully present in the U.S. in the future and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. This opportunity begins the month you regain lawful presence status and lasts for two additional months. If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after you become lawfully present in the U.S., you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

Who can I call to get more information?
You can call Social Security at 1-800-772-1213, if you have questions about your lawful presence status. TTY users should call 1-800-325-0778. If you have questions about your Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 6, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
18. Approve New CalOptima Health Policy MA.7020p: Behavioral Health Services.

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Carmen Katsarov, Executive Director, Behavioral Health Integration, (714) 796-6168

Recommended Action
Approve CalOptima Health Policy MA.7020p: Behavioral Health Services.

Background/Discussion
On January 1, 2023, the Cal MediConnect program transitioned to Medi-Medi Plans (MMPs). MMPs is the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs). Under exclusively aligned enrollment, beneficiaries can enroll in a D-SNP for Medicare benefits and in a Medi-Cal managed care plan for Medi-Cal benefits, which are both operated by the same parent organization for better care coordination and integration.

MMPs offer an integrated approach to care and care coordination that is like Cal MediConnect. The MMPs will work together to deliver all covered benefits to their members, and members will receive integrated member materials, such as one integrated member ID card.

With the transition of OneCare Connect members to the OneCare line of business, staff have drafted Policy MA.7020p: Behavioral Health Services to define the scope of behavioral health services for OneCare members. The policy addresses the following elements: (1) outpatient mental health care; (2) inpatient mental health care; (3) opioid treatment program services; (4) depression screening; (5) screening, assessment, briefing interventions and referral to treatment (SABIRT); (6) authorization requests; (7) prior authorizations; (8) coordination with Enhanced Care Management (ECM); and (9) information exchange.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in CalOptima Health's Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation
CalOptima Health staff recommends that the Board approve and adopt Policy MA.7020p: Behavioral Health Services to ensure CalOptima Health can effectively transition former OneCare Connect members into a OneCare program that aligns with the requirements set forth by DHCS and CMS for EAE D-SNPs.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. New CalOptima Health Policy MA.7020p: Behavioral Health Services

/s/ Michael Hunn *03/30/2023*
Authorized Signature **Date**

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Policy:	MA.7020
Title:	**Behavioral Health Services**
Department:	Medical Management
Section:	Behavioral Health Integration
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope of Behavioral Health Services for OneCare Members.

II. POLICY

A. CalOptima Health shall offer the following Behavioral Health Services:

1. Outpatient mental health care:
    a. Clinic services;
    b. Day treatment;
    c. Psychosocial rehab services;
    d. Partial hospitalization/Intensive outpatient programs;
    e. Individual/group mental health evaluation and treatment;
    f. Psychological testing;
    g. Outpatient services for the purposes of monitoring drug therapy;
    h. Outpatient laboratory, drugs, supplies and supplements; and
    i. Psychiatric consultation.
2. Inpatient mental health care;
3. Opioid treatment program services;
4. Depression screening; and
5. Screening, Assessment, Briefing Interventions and Referral to Treatment.

B. CalOptima Health shall not impose quantitative or non-quantitative treatment limitations more

stringently on covered Behavioral Health Services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), section 438.900.

C. CalOptima Health and its Health Networks contracted Primary Care Practitioner/Physicians (PCPs) shall be responsible for screening and providing Behavioral Health Services within the scope of their practice.

D. CalOptima Health and its Health Networks shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum standards, when applicable, in accordance with CalOptima Health Policies HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI), HH.3010: Protected Health Information (PHI) Disclosures Required by Law, and HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations.

E. CalOptima Health and its Health Networks shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with CalOptima Health Policies HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

F. CalOptima Health shall ensure timely access to Behavioral Health Services as set forth by the Department of Managed Health Care (DMHC) and CalOptima Health Policy MA.7007: Access and Availability.

G. If Behavioral Health Services that are the responsibility of CalOptima Health are unavailable to the Member, CalOptima Health shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals, and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

H. CalOptima Health shall not require a referral from a PCP or Prior Authorization for an initial outpatient mental health assessment performed by a contracted mental health Provider.

I. CalOptima Health shall ensure that all contracted and non-contracting mental health Providers are informed of the Prior Authorization and referral process. Prior Authorization requirements for services covered by CalOptima Health shall be in compliance with the requirements for parity in mental health and substance use disorder benefits in Title 42 Code of Federal Regulations (CFR) section 438.910(d).

J. CalOptima Health shall follow authorization guidelines in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, GG.1508: Authorization and Processing of Referrals and GG.1501: Inpatient Length of Stay Assignment, when authorizing Behavioral Health Services.

K. CalOptima Health shall maintain a twenty-four (24) hour/seven (7) day week direct telephone line for emergencies and assistance during non-business hours.

L. CalOptima Health and its Health Networks shall identify and refer an eligible Member to the Orange County Mental Health Plan (OC MHP) managed by the Orange County Health Care Agency (OCHCA) for the provision of Medi-Cal Specialty Mental Health Services (SMHS).

1. The OC MHP shall provide SMHS to a Member, in accordance with Title 9, California Code of Regulations (CCR), sections 1820.205, 1830.205 and, and in accordance with CalOptima Health and OC MHP Coordination and Provision of Behavioral Healthcare Services Contract.

M. CalOptima Health and its Health Networks shall identify and refer an eligible Member to the Orange County Health Care Agency's Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

N. CalOptima Health and its Health Networks shall coordinate for all Medically Necessary physical health care services, emergency, and Non-Emergency Medical Transportation (NEMT) in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical, and for all covered psychotropic drugs for Members referred by OC MHP and Drug Medi-Cal Providers as per the Contract between CalOptima Health and OC MHP.

O. CalOptima Health and its Health Networks shall request and facilitate the participation of OC MHP in Interdisciplinary Care Team (ICT) conference.

P. CalOptima Health shall require interagency meetings occur at least quarterly to review the care coordination process and implement interventions to improve performance, where opportunities for improvement are identified.

Q. CalOptima Health and its Health Networks shall implement a mechanism for the identification and referral of quality of care and service delivery issues to CalOptima Health's Quality Improvement (QI) Department.

III. PROCEDURE

A. Medical Provider Responsibilities for Screening, Referral and Intervention for Behavioral Health and Substance Use Disorder (SUD) Services include:

1. For SUD services, providers within their scope of practice shall:

a. Administer an approved screening tool for identifying unhealthy alcohol or drug use;

b. Provide behavioral counseling intervention on identified issue(s);

c. Provide Member referral to SUD treatment when there is a need beyond screening or counseling interventions;

d. Refer a Member to the OCHCA DMC-ODS for additional assessment and counseling, if necessary; and/or

e. A PCP or medical provider can access the CalOptima Health Behavioral Health Line for any coordination of care or assistance needed.

2. For mental health, a PCP or other medical provider shall:

a. Screen and provide mental health services, within the scope of their practice; and/or

b. Refer a Member for further mental health services through the CalOptima Health Behavioral Health Line, OCHCA OC MHP for SMHS as needed.

B. Accessing CalOptima Health Behavioral Health Services

1. A Member may access Behavioral Health Services through the CalOptima Health Behavioral Health Line for assistance with obtaining a mental health assessment from a licensed mental health Provider within the CalOptima Health's Provider network at any time.

2. A Member may be referred to the CalOptima Health Behavioral Health Line from the following:

   a. OCHCA's OC MHP Access Line or DMC-ODS;

   b. Self-referral;

   c. Authorized Representative or caregiver;

   d. PCP or another medical provider;

   e. Specialty Care Provider;

   f. Behavioral health specialist;

   g. Long-Term Support Services (LTSS) Provider;

   h. Community-based agency;

   i. Internal CalOptima Health Departments including Population Health Management, Case Management, and Customer Services staff or discharge planner; and

   j. Other Member's identified health care team providers.

C. CalOptima Health Behavioral Health Integration Call Center

1. CalOptima Health Behavioral Health Line Number: (855) 877-3885

2. CalOptima Health Behavioral Health Line requirements shall include:

   a. 24/7 availability in compliance with telephone access standards in accordance with CalOptima Health Policy MA.7007: Access and Availability;

   b. Utilizing linguistic interpreter services, or the California Relay Service (711) for Members, as necessary to ensure effective communication;

   c. Verifying the caller's eligibility and Health Network assignment;

      i. If the caller is not a One Care Member and not in crisis, call center staff shall refer the caller to his/her primary health insurance and suggest a community resource for treatment of their described symptoms.

   d. Identifying and triaging callers based on their initial reason for contacting the CalOptima Health Behavioral Health Line;

   e. Screening and determination for routine, Urgent or Emergent needs. If determined Urgent or Emergent, call center staff shall immediately complete safety screening;

f. If a caller's needs are indicated as requiring Emergent or Urgent Services, call center staff shall make a referral to OCHCA's Centralized Assessment Team (CAT) and/or contact the other appropriate emergency agencies;

g. Call center staff must link Emergent calls immediately, and/or not more than two (2) hours after the determination that the call is Emergent;

h. Call center staff must link Urgent calls for services within twenty-four (24) hours after making the determination that the call is Urgent;

i. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to services and/or the appropriate agencies; and

j. If the caller is determined to be a beneficiary assigned to CalOptima Health with a mental health need the call center staff shall conduct a brief telephone clinical screening to verify appropriate level of services.

3. As a result of the brief telephone clinical screening:

a. If it is determined the Member needs Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the CalOptima Health behavioral health network, are currently accepting CalOptima Health OneCare Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to CalOptima Health Policy MA.7007: Access and Availability.

b. If CalOptima Health's screening suggests a Member will benefit from case management services for the mental health condition and qualifies for SMHS provided by OC MHP, then CalOptima Health will forward, via secure protocol, the screening tool to the appropriate contact at OC MHP for referral of services.

c. If further assessment and treatment for alcohol and/or substance use is determined, the CalOptima Health Behavioral Health Line staff shall warm transfer the Member to the OCHCA DMC-ODS for DMC services.

d. CalOptima Health Behavioral Health Line staff will provide ongoing assistance when needed and/or requested with Member or authorized representative to coordinate with OCHCA as needed to ensure proper linkage and support.

D. Authorization Request Types

1. Provider or Practitioner and/or facility may request routine, urgent, and retrospective review in accordance with CalOptima Health Policy GG:1508 Authorization and Processing of Referrals.

E. Prior Authorization

1. CalOptima Health shall process requests for Prior Authorization within the timeframes specified in GG.1508: Authorization and Processing of Referrals. CalOptima Health shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

a. General Standards

i. If CalOptima Health does not take action by approving, denying, deferring, or modifying services, on a routine written request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service is sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

ii. CalOptima Health shall maintain a system for tracking all referrals for Provider and Member-requested health care services and supplies. The system, at a minimum, must track:

a) Referral turnaround time for issuing a determination;

b) Criteria used in making the determination. If denied, deferred, or modified a copy of the Integrated Denial Notice (IDN) and

c) Specific services approved, denied, deferred, or modified.

iii. A Practitioner or Provider shall request Prior Authorization for services for a Member, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

iv. Services Excluded from the Prior Authorization Process

a) Emergency Services and emergency care do not require Prior Authorization, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

1) CalOptima Health shall not require notification for Emergency Services and does not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2) CalOptima Health shall not refuse to cover Emergency Services based on the emergency room provider, or hospital or fiscal agent not notifying the Member's PCP or CalOptima Health of the Member's screening and treatment.

3) CalOptima Health shall not require Prior Authorization for emergency care, following the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint is an emergency.

v. Hospital Services

a) A contracted hospital shall notify CalOptima Health of a Member's inpatient admission within twenty-four (24) hours of the admission.

b) All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.

c) A decision will be made on an initial request within seventy-two (72) hours of the request.

d) Concurrent review will be completed every forty-eight (48) to seventy-two (72) hours during the inpatient stay.

vi. Provider

a) The Hospital/Provider shall notify the Member's PCP.

b) The Hospital/Provider shall admit the Member to the appropriate Provider or Specialist Physician, based on the instructions from the Member's Health Network.

c) Hospital/Provider shall coordinate timely Discharge Planning so that the Member's anticipated needs are met, and discharge plan is continued to the next appropriate level of care following facility discharge.

vii. Out-of-Network Services

a) CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

b) CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

viii. Prior Authorization Procedure

a) CalOptima Health's BH UM Department shall provide Members or potential Member's access to information, about the UM process, and the process for authorizing care, in the OneCare Evidence of Coverage, available in-print and on the CalOptima Health website at www.CalOptima.org.

b) CalOptima Health's BH UM Department shall provide Physician access to information about the BH UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima Health website at www.CalOptima Health.org.

ix. Denials, Dismissals, and Modifications of Prior Authorization Requests

a) CalOptima Health shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage.

b) In the event a Prior Authorization request is denied, dismissed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify in writing the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

F. Coordination with Enhanced Care Management (ECM)

1. CalOptima Health and its Health Networks shall coordinate care for Members enrolled in Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-

Cal for All (CalAIM) initiative in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced Care Management Service Delivery, and GG.1354: CalAIM Enhanced Care Management Eligibility and Outreach.

2. Members with Original Medicare, a Medicare Advantage Plan or a Dual-Eligible Special Needs Plan shall be authorized for ECM if they are referred, meet criteria for (1) one or more of the Populations of Focus (POF) and agree to participate.

3. Coordination with SMHS and OCHCA

   a. CalOptima Health and its Health Networks shall coordinate a Member's care with OCHCA OC MHP to ensure:

      i. The provision of all Medically Necessary Covered Services;

      ii. The provision of care management while Members are receiving SMHS, in accordance with CalOptima Health Policy MA.6009: Care Management and Coordination Process;

      iii. Identification and referral of eligible Members to LTSS and community-based services and benefits;

      iv. OCHCA OC MHP Provider or representative participate in the Member's ICT;

      v. PCP provides copy of Member's Individual Care Plan (ICP) to OC MHP Provider;

      vi. OCHCA OC MHP updates PCP of changes; and

      vii. PCP updates OCHCA OC MHP Provider of changes.

   b. CalOptima Health and its Health Networks shall ensure provision of care management while Members are receiving services from OCHCA DMC-ODS.

      i. The OCHCA DMC-ODS Provider, or representative, shall be invited to participate in the Member's ICT;

      ii. The PCP shall provide copy of ICPs to the DMC-ODS Provider;

      iii. The OCHCA DMC-ODS Provider shall provide updates to the PCP; and

      iv. The PCP shall provide updates to the OCHCA DMC-ODS.

G. Information Exchange

1. CalOptima Health and its Health Networks or the OCHCA OC MHP shall ensure that there is a Release of Information signed by the Member. The form shall:

   a. Be signed within the current Episode of Care (EOC), established either upon the opening of a new Member case or if currently under OCHCA OC MHP Provider care, as discovered during Member's annual medical visit;

   b. Identify CalOptima Health, OCHCA OC MHP, OCHCA Drug Medi-Cal, and/or other program(s) providing services in which information should be shared;

c. Identify which types of information can be shared;

d. Be placed in the Member's chart along with other Releases of Information; and

e. Be void at the end of the current EOC and require renewal upon each new EOC.

2. All Providers rendering services to the Member shall ensure that only the minimum information necessary will be exchanged in accordance with the terms and conditions of this policy and CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls, in order to protect the Member's privacy to the fullest extent. This information will be exchanged in an effort to provide coordination between medical and behavioral health services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Coordination and Provision of Behavioral Healthcare Services Contract/MOU between CalOptima Health and OC MHP
B. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
C. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management Eligibility and Outreach
D. CalOptima Health Policy GG.1501: Inpatient Length of Stay Assignment
E. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
F. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
I. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
J. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls
K. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)
L. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Required by Law
M. CalOptima Health Policy HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations
N. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information
O. CalOptima Health Policy MA.4001: Member Rights and Responsibilities
P. CalOptima Health Policy MA.4002: Cultural and Linguistic Services
Q. CalOptima Health Policy MA.6009: Care Management and Coordination Process
R. CalOptima Health Policy MA.7007: Access and Availability
S. CalOptima Health Policy MA.9002: Member Grievance Process
T. CalOptima Health Policy MA.9006: Provider Complaint Process
U. CalOptima Health Utilization Management Program
V. Title 9, California Code of Regulations (CCR), §§ 1820.205, 1830.205, and 1830.210
W. Title 22, California Code of Regulations (CCR), §§ 51159, 51303, and 54301
X. Title 42, Code of Federal Regulations (CFR), Section 438.900

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	MA.7020	Behavioral Health Services	OneCare

IX. GLOSSARY

Term	Definition
Appeals	Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both mental health and substance use disorder services, as covered by CalOptima Health.
CalOptima Health Behavioral Health Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours/ seven (7) days a week) to obtain referrals for all CalOptima Health Covered Outpatient Mental Health Services. This line has a live operator at all times and telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.
Complaint	A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under Center for Medicare & Medicaid Services (CMS).
Department of Managed Health Care (DMHC)	The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Drug-Medi-Cal Organized Delivery System (DMC-ODS)	Program under which each county enters into a contract with the Department of Health Care Services (DHCS) for the provision of a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care.

Term	Definition
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Emergency Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.
Emergent Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.
Episode of Care (EOC)	The set of services provided to treat a clinical condition or procedure.
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 Health to provide Covered Services to Members assigned to that Health Network.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other Providers at the discretion of the Member, that work with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled Nursing Facility services and subacute care services.
Medically Necessary / Medical Necessity	The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
Medi-Cal Specialty Mental Health Services (SMHS)	Specialty mental health services are provided through a Mental Health Provider, in accordance with Chapter 11 of Division 1 of Title 9 of the CCR and include: 1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services; 2. Psychiatric inpatient hospital services; 3. Targeted Case Management; 4. Psychiatrist services; and 5. Psychologist services.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.

Term	Definition
Mental Health Plan (MHP)	Pursuant to California Code of Regulations, Title 9 section 1810.226, an MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment, or Health Care Operations.
Non-Emergency Medical Transportation (NEMT)	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 Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
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 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.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: 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 Health 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.

Term	Definition
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Physician.
Specialty Care	Refers to higher-level medical services that require a referral from a primary care provider. Physicians who provide specialty care undergo extensive training to "specialize" in a given area of medicine, for example, oncology, cardiology, etc.
Threshold Languages	A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely mental health intervention that shall be appropriate to the severity for the condition.

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