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

THURSDAY, FEBRUARY 25, 2021
3:00 P.M.

505 CITY PARKWAY WEST, SUITE 108-N
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Mary Giammona, M.D., Chair
Trieu Tran, M.D.

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

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to 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' Quality Assurance Committee, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee 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 of Directors' Quality Assurance Committee Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org
Committee meeting audio is streamed live on the CalOptima website at www.caloptima.org.

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

1) **Listen to the live audio at +1 (562) 247-8321 Access Code: 801-683-433 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/2471079128916725007 rather than attending in person. Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

MANAGEMENT REPORTS
1. Chief Medical Officer – COVID-19 Update

CONSENT CALENDAR
2. Approve Minutes of the December 10, 2020 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
3. Receive and File 2020 CalOptima Quality Improvement Program Evaluation

4. Consider Recommending Board of Directors Approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

5. Receive and File 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation

6. Consider Recommending Board of Directors Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

7. Consider Recommending Board of Directors Approval of the 2020 CalOptima Utilization Management Program Evaluation and the 2021 CalOptima Utilization Management Program Description

8. Consider Recommending Board of Directors Approval of Modifications to Quality Improvement Policies

INFORMATION ITEMS
9. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

10. 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

ADJOURNMENT

How to Join

1. Please register for Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee on February 25, 2021 at 3:00 PM PDT at: https://attendee.gotowebinar.com/register/2471079128916725007

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

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

   --OR--

   TO USE YOUR TELEPHONE:

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

   United States: +1 (562) 247-8321

   Access Code: 801-683-433

   Audio PIN: Shown after joining the webinar

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Population Health COVID-19 Vaccine and Member Outreach Strategy

Board of Directors' Special Quality Assurance Committee Meeting

February 25, 2021

Emily Fonda, MD, MMM, CHCQM

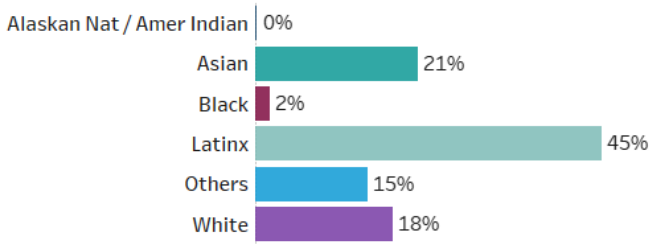
Interim Chief Medical Officer

Back to Agenda

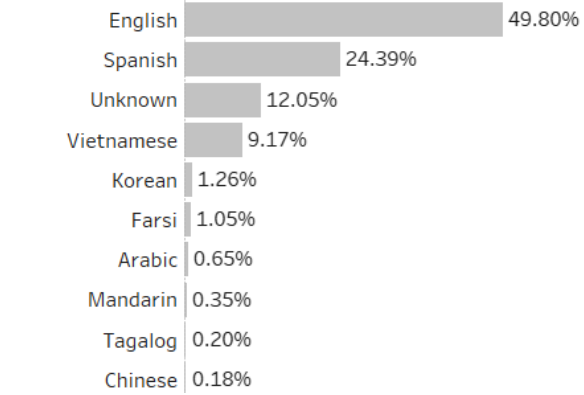
CalOptima Population Analysis by COVID-19 Risk Factors

All Total Members	All High Risk Conditions	All Experiencing Homelessness	All LTC Residents
806,334	200,978	12,130	4,148

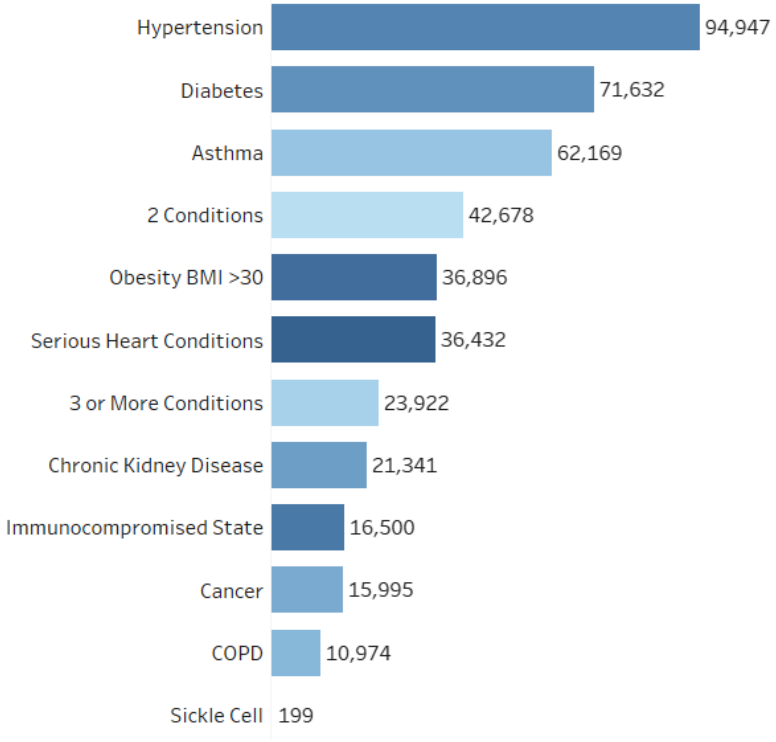
Member Counts by Ethnicity: All



Member Counts: Top Ten Languages: All



Member Counts by High Risk Condition: All



Chronic Conditions in "2 Conditions" and "3 or More Conditions" include Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Diabetes and Hypertension (HTN)

Data pulled on December 28, 2020, Data Source: CalOptima Enterprise Analytics; Condition Prevalence; Time Frame: December 20, 2019–November 20, 2020; EA_EQ_Member Detail; Time Frame: December 2020; Programs: All

Back to Agenda

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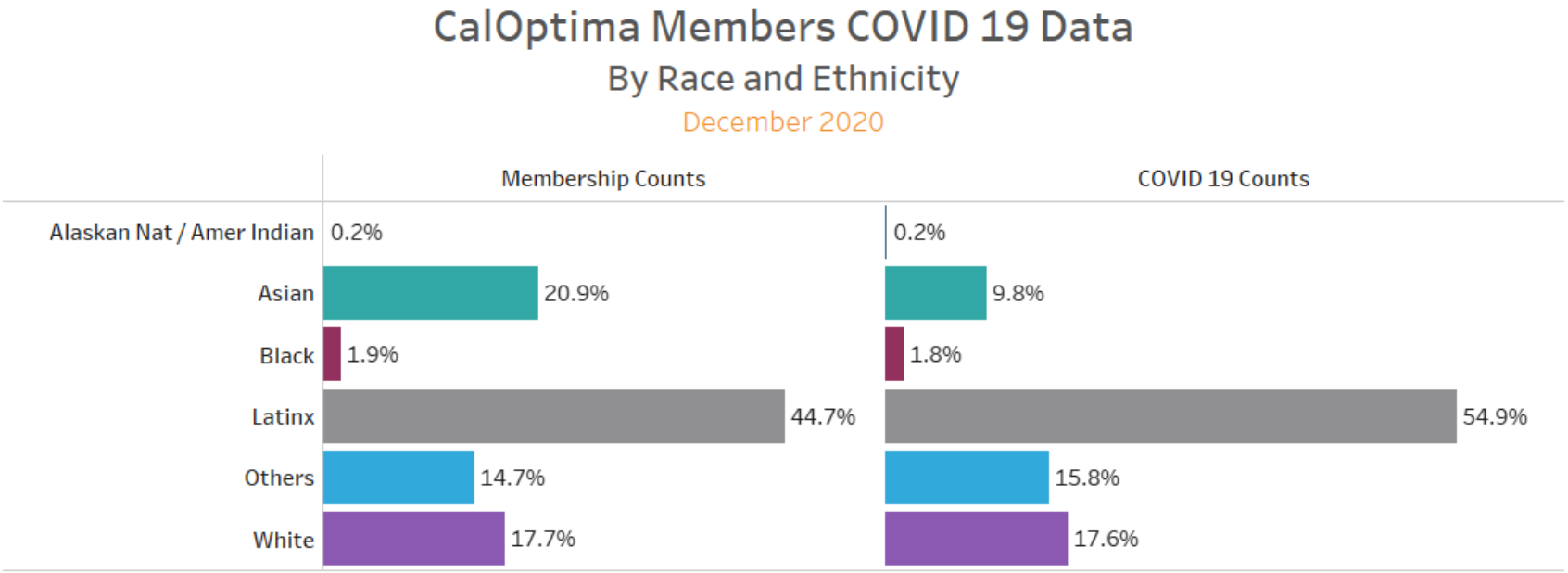
CalOptima Members COVID-19 Data: December 2020

- Latinx account for 54.9% of coronavirus cases and make up 44.7% of the CalOptima's membership
- Blacks account for 1.8% of cases and make up 1.9% of the membership



COVID 19 cases coded in Claims and Encounters received though 12/18/20

Ongoing COVID-19 Efforts

- Orange County Nursing Home Program
  - Intensive infection protection training began June 1, 2020 in collaboration with the HCA and conducted by UCI epidemiology team in anticipation of the fall COVID-19 resurgence
- Post-Acute Infection Prevention Quality Incentive Initiated October 2019
  - Supports the substitution of regular liquid soap with chlorhexidine soap (antibacterial, anti-viral, anti-fungal for 24 hours) in nursing homes
  - Ongoing program in 27 facilities with plans for expansion

Back to Agenda

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Ongoing COVID-19 Efforts (cont.)

- Virtual Urgent Care Pilot
  - Virtual urgent care eVisits
    - Allows after-hour access for all CalOptima members regardless of network assignment for behavioral health (BH) conditions/non-BH care for CCN only
    - Telehealth coverage for BH — also provided by vendor Bright Heart with limited number of providers
    - Goals — to assist with access and availability issues and offload provider offices with limited capacity during the pandemic
  - Virtual care eConsults
    - Provider to provider consultation that alleviates the waiting time for a specialty referral and may eliminate the need for a face to face visit
    - Goal — to assist with access and availability issues

Back to Agenda

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COVID-19 Vaccination Outreach and Member Incentive

- Initiative Description
  - Outreach to members via mail, texting and phone calls
  - Host vaccination events in hard-to-reach communities in collaboration with HCA and health networks
  - Partner with community-based organizations (e.g., food pantries) to bring additional resources to the event
  - Leverage CalOptima non-medical transport to bring members to/from vaccination events
  - Member quality incentives of $25 non-monetary gift cards for each vaccine
    - $35 million approved by the BOD on January 7, 2021

Back to Agenda

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Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy

- One-year Homeless Health Initiative (HHI) — up to $400,000 for non-monetary member incentives to promote COVID-19 vaccination while addressing social determinants of health (SDoH)
  - A $25 quick service restaurant gift card per vaccination for members receiving the COVID-19 vaccines
  - Non-monetary incentives in an amount not to exceed $50
- Collaborate with community partners serving the homeless to support vaccination at shelters, recuperative care sites and other hot spots
  - Orange County Health Care Agency and Coalition of Community Clinics/Clinical Field Teams

Back to Agenda

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Member Vaccination Strategy

- Utilization of the County Vaccine Hesitancy Survey
  - Important reasons to vaccinate as messaging to members
- Support the County Vaccine Equity Pilot Program (VEPP)
  - Close collaboration with OCHCA (Dr. Clayton Chau)
  - Endorse vaccine confidence and use of the Othena App
  - COVID 19 Vaccine Rollout Plan as a joint effort
    - Identify target populations in eligible tiers
    - Direct vaccine distribution among CalVAX-approved providers within Health Networks (HN) according to the weekly County allocation
    - Repeat the process until the first doses are completed and apply the same process to secure the second dose

Back to Agenda

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COVID-19 Communications Strategy

- Awareness campaign
  - Through print, outdoor, radio, digital and social media
- Collateral materials
  - Member frequently asked questions (FAQs), member newsletters, PHM mailings, provider FAQs, provider updates, community updates
    - Direct mail, website, member portal, social media and virtual events
- Community outreach
  - Partnerships, panel discussions and town halls
- Media pitching
  - Newspapers, TV, radio and op-ed

Back to Agenda

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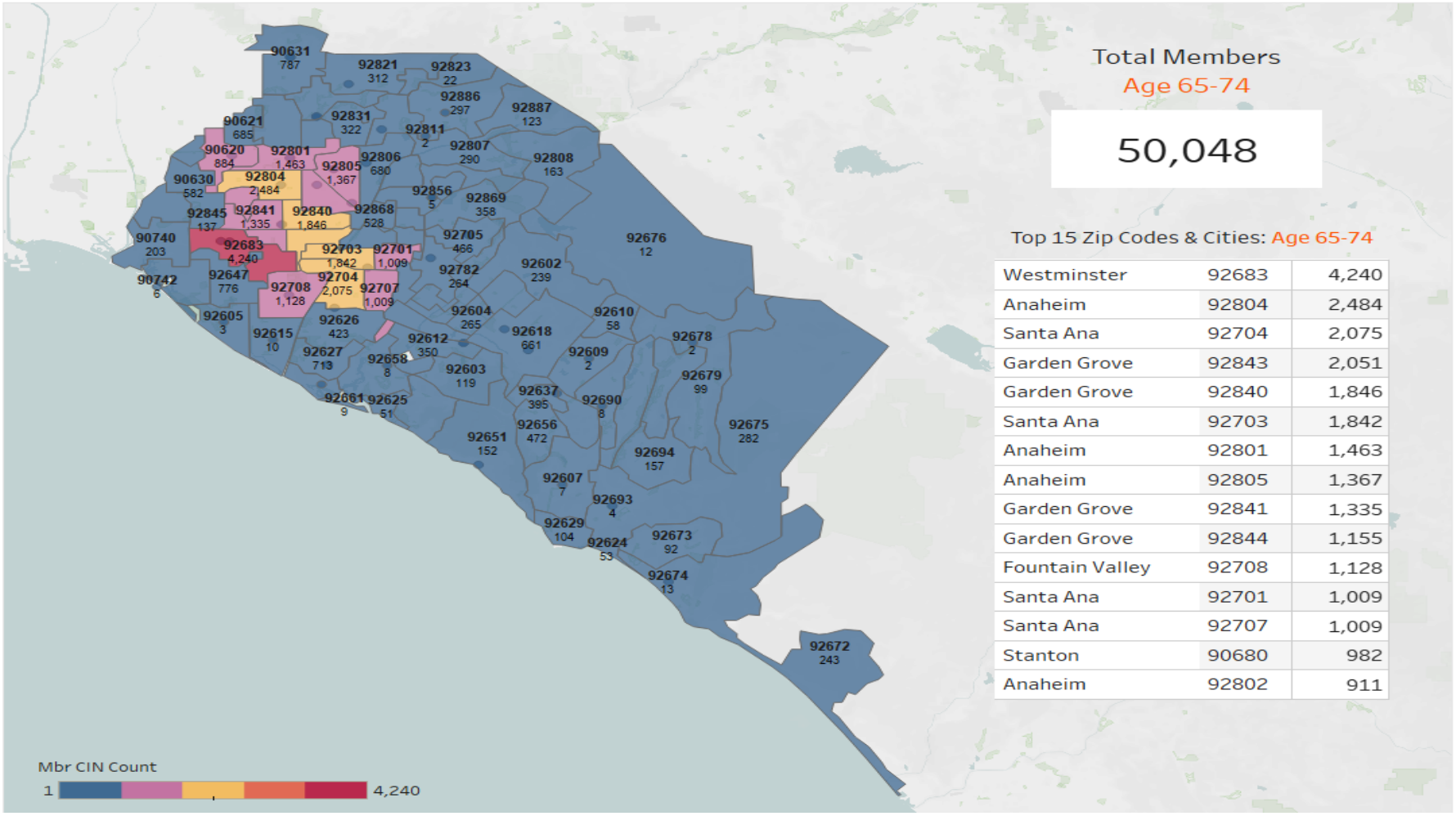
Members Ages 65–74 by City and Top ZIP Codes



Total Members
Age 65-74

50,048

Top 15 Zip Codes & Cities: Age 65-74

Westminster	92683	4,240
Anaheim	92804	2,484
Santa Ana	92704	2,075
Garden Grove	92843	2,051
Garden Grove	92840	1,846
Santa Ana	92703	1,842
Anaheim	92801	1,463
Anaheim	92805	1,367
Garden Grove	92841	1,335
Garden Grove	92844	1,155
Fountain Valley	92708	1,128
Santa Ana	92701	1,009
Santa Ana	92707	1,009
Stanton	90680	982
Anaheim	92802	911

Data pulled on December 29,2020. Data Source: CalOptima Enterprise Analytics; EA_MemberCurrentMonth; Time Frame: December 2020; Programs: All

Back to Agenda

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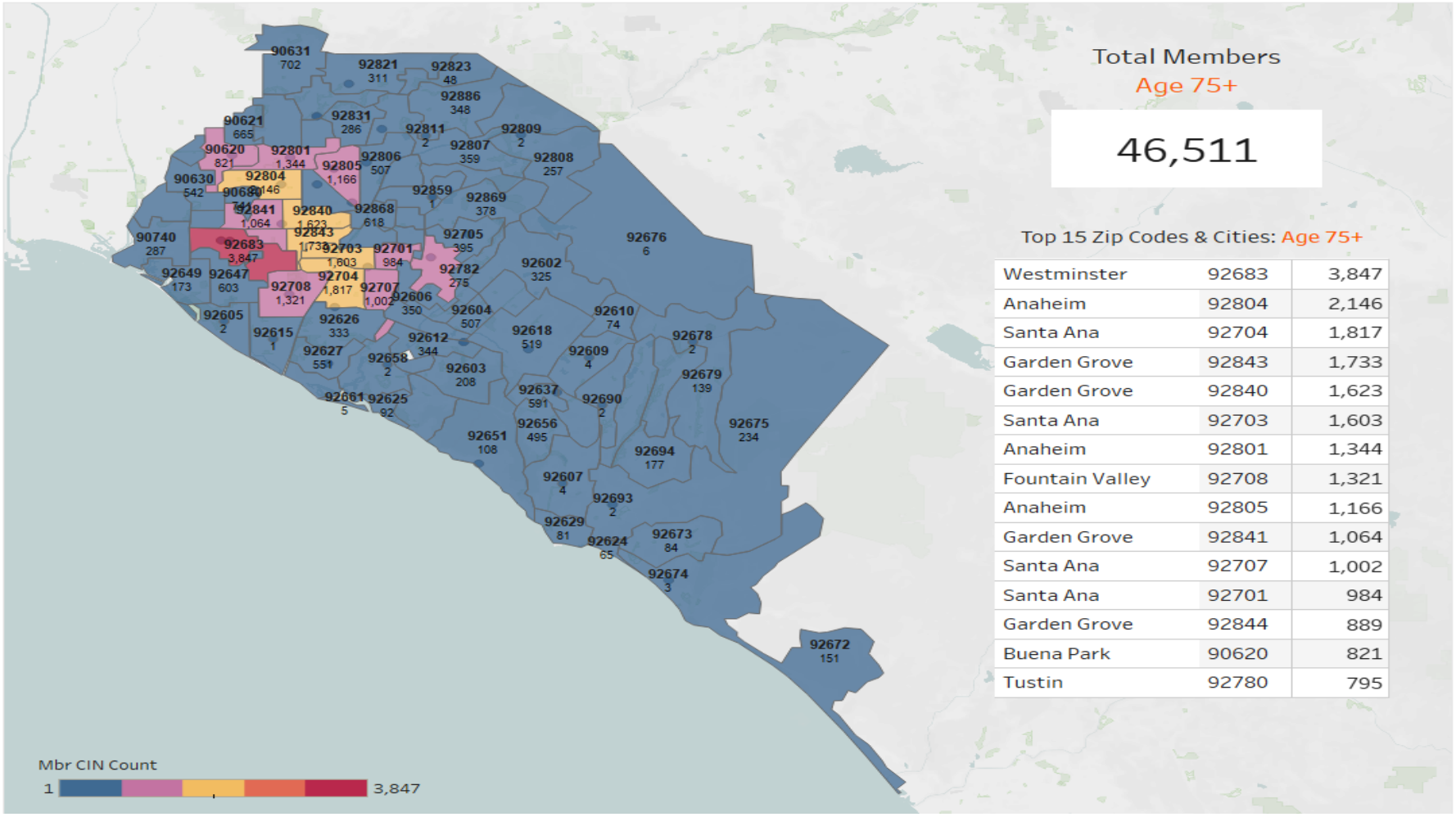
Members Age 75+ by City and Top ZIP Codes



Total Members
Age 75+

46,511

Top 15 Zip Codes & Cities: Age 75+

Westminster	92683	3,847
Anaheim	92804	2,146
Santa Ana	92704	1,817
Garden Grove	92843	1,733
Garden Grove	92840	1,623
Santa Ana	92703	1,603
Anaheim	92801	1,344
Fountain Valley	92708	1,321
Anaheim	92805	1,166
Garden Grove	92841	1,064
Santa Ana	92707	1,002
Santa Ana	92701	984
Garden Grove	92844	889
Buena Park	90620	821
Tustin	92780	795

Data pulled on December 29, 2020. Data Source: CalOptima Enterprise Analytics EA_MemberCurrentMonth; Time Frame: December 2020; Programs: All

Back to Agenda

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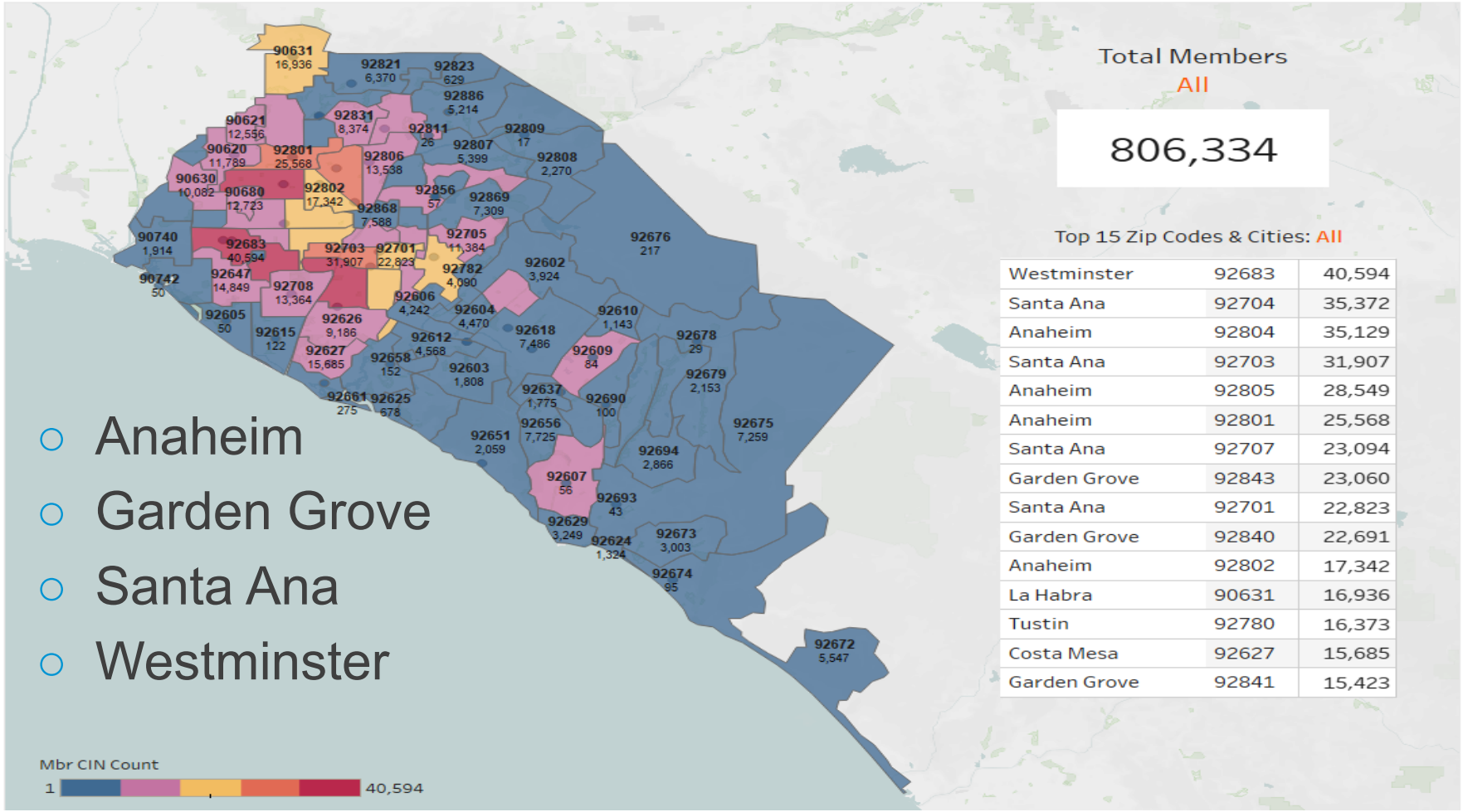
Recommendation for Targeted Vaccine Events



Data pulled on December 29, 2020. Data Source: CalOptima Enterprise Analytics; EA_MemberCurrentMonth; Time Frame: December 2020; Programs: All

Back to Agenda

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Our Mission

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

Back to Agenda

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 10, 2020

A Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on December 10, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

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

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

Members Absent: None

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

PUBLIC COMMENTS
There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Medical Officer Update

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

Back to Agenda

CONSENT CALENDAR

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

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

REPORTS

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

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

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

INFORMATION ITEMS

4. Behavioral Health Interventions During COVID-19 Pandemic

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

5. Access and Availability Report

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

6. Population Health Equity Analysis

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

Back to Agenda

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

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

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

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

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

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

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 25, 2021

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2020

QUALITY IMPROVEMENT EVALUATION

Back to Agenda

2020 QUALITY IMPROVEMENT EVALUATION SIGNATURE PAGE

Quality Improvement Committee Chair:

Emily Fonda, M.D., MMM, CHCQM **Date**

Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Mary Giammona, M.D. **Date**

TABLE OF CONTENTS

2020 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2020 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities initiated in 2019 which impacted results in 2020, as well as activities undertaken during the first three quarters of the 2020 calendar year to improve health care and services available to CalOptima members.

The final 2020 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2021 to the Quality Improvement Committee (QIC). The 2020 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2021 QI Program and its Work Plan.

The year 2020 is unprecedented as a result of the COVID-19 pandemic. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance's with flexibility in regulations addressing member access to care during the pandemic. It addressed Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth; APL 19-009 Supplement: Emergency Telehealth Guidance — COVID-19 Pandemic; and CMS' telehealth guidelines. The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services during the COVID-19 pandemic.

CalOptima pivoted quickly in response to the pandemic including acceleration of the Virtual Care Strategy, expanding access to virtual mental health care with trauma informed care capabilities, and implementing a hybrid approach to member outreach and education to ensure patient safety during the pandemic. CalOptima continued to focus on advancing QI initiatives to achieve 2020 Quality Improvement (QI) goals and objectives to provide members with access to quality health care services in person or leveraging telehealth technology.

CalOptima achieved many of its organizational objectives in 2020:

- Recognized by DHCS as the highest performing Medicaid plan in California.
- All DHCS managed care accountability set (MCAS) measures required to achieve a Minimum Performance Level (MPL) were met in measurement year (MY) 2019. This is a significant achievement as the DHCS raised the MPL from the 25th to the 50th national percentile for MY2019.
- Performed successful incentive outreach to members to obtain preventive care. In 2019, there were outreach programs which demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, breast and cervical cancer screening.
- CalOptima's comprehensive health network (HN) and CalOptima Community Network (CCN) Pay for Value (P4V) Performance Measurement Program continued to recognize and reward outstanding performance and support ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The P4V program is a significant driver of our achievement of the MPL for all DHCS required measures.

- In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 through 2020, for the Clinical Field Team (CFT) and Community Health Centers (CHCs). Telehealth visits were added due to COVID-19, while we continued providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots.
- CalOptima has been accepted to participate in the ***California Heath Care and Homeless Learning Community***. CalOptima's Homeless Health Initiative was selected in October 2020 among more than 40 applications, as one that stood out to the external review committee.
- Post-acute Infection Prevention Quality Incentive (PIPQI) was implemented on October 1, 2020 to reduce post-acute infections at 25 nursing facilities of which 12 were already participating with University California, Irvine (UCI) since Q2 2017 in the study for Share Healthcare Intervention to Eliminate Life-threatening Dissemination (SHIELD) of multi-drug resistant organisms (MDROs). In addition, CalOptima in partnership with UCI and the Orange County Health Care Agency (HCA), participated in the Orange County Nursing Home Infection Prevention program to create safety toolkits and instructional videos to reduce the spread of COVID-19 in nursing homes.
- Implemented preventive care and flu campaign in response to COVID-19 pandemic. CalOptima used a combination of interactive voice response (IVR) (landlines only), member mailings, on-hold messaging, educational videos to member website and social media platforms and infomercials on Public Broadcasting Service (PBS) Kids.

For 2020, CalOptima had adequate staffing, resources, and a well-defined quality committee structure in place to meet the required needs of the QI program. The QI program structure includes a Quality Improvement Committee (QIC), with several subcommittees reporting to the QIC, which included the Whole-Child Model Clinical Quality Committee (WCM CAC), Utilization Management Committee (UMC), Credentialing and Peer Review Committee (CPRC), Member Experience Committee (MEMX), and Grievance Appeal and Resolution (GARS) Committee. The QIC had exceptional participation from external and internal practitioners as well as staff.

CalOptima implemented in 2020, a robust population health management (PHM) strategy to focus on various conditions ranging from cancer screenings to managing patients with multiple complex conditions. The program had strong member and provider engagement, which was monitored on a quarterly basis. In response to the COVID-19 pandemic and amplification of health disparities for persons of color, CalOptima conducted a population segment analysis based on race and ethnicity. The population segment analysis results and opportunities to improve health equity will be incorporated in the 2021 QI Program. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2020 that will continue into 2021. These initiatives are focused on long-term improvement efforts for selected high priority measures.

In 2021, based on the 2020 QI Program Evaluation, CalOptima will continue its PHM strategy in alignment with CalOptima's strategic priorities to focus on activities and incentives that will improve member engagement, access to care and quality outcomes.

Recommendations for 2021

1. Continue member "health rewards" incentive program, specifically for preventive screenings, but expand and transition to a more comprehensive member health rewards program that reinforces reaching and maintaining health goals and narrowing gaps in care. Work collaboratively with HNs to widen the promotion of member health and wellness. Utilize a third-party vendor to offset intense staff resources required to process member incentives.
2. Intensify targeted member outreach, by utilizing multiple modes of communications per members preference, either through website, direct mailings, email, IVR calls, and mobile

texting. Leverage more electronic means versus resource intensive direct member outreach, as part of a more robust user-friendly communication/touchpoint plan.

3. Continue to utilize P4V Measure set to drive improvement on MCAS measures. Staff will consider the addition of new access measures to the P4V program for MY2021.
4. Institute new behavioral health (BH) P4V program in 2021 to help drive improvement in BH measures.
5. Prioritize data bridge efforts to improve data exchanges, both at the HN level and plan level in anticipation of many hybrid measures converting to administrative measures. Continue data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 include improving access to electronic medical record systems; and remedy the lab data gap not currently available through limited contract data exchanges.
6. Expand virtual care strategies to increase access to care for members, such as BH Virtual Care visits, e-visits, e-consults and telehealth for CalOptima's Program of All-Inclusive Care for the Elderly (PACE).

During 2020, it has been a year of uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that will continue to impact lives locally, nationally and globally into 2021. Considering the appointment of three new members of the Board Quality Assurance Committee in 2020, the CalOptima QI Program and Work Plan for 2021 will be flexible to align with the new strategic goals and objectives as defined by the new Board. Staff will remain agile in the shifting health care landscape while continue to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

SECTION 1: QUALITY IMPROVEMENT PROGRAM STRUCTURE

Activities in the 2020 QI Program and associated Work Plan focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for our members.

QI Program Documents

- **Annual Evaluation** — Completed a comprehensive evaluation of the QI program at the end of the fiscal year that assesses the performance of measures/indicators that are part of the QI program.
- **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI program by including "new initiatives" in the QI program description that will outline measurable goals and objectives that the organization is going to focus on in subsequent years.
- **Work Plan** — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year dependent on priorities and opportunities.
- **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to members.

Reviews of QI Documents

- CalOptima successfully completed reviews of all of the above documents with the QI committees during 2020. The documents were reviewed and approved by the CalOptima Board of Directors.
- Feedback from the practitioners that participated in the QI committee meetings were included in program documents (i.e. Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

Provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.

- The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
- The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2020. This gave the QI department a framework on how to start implementing the QI program throughout 2020. For the remainder of the year, the QI staff updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on improving performance improvement activities directed towards clinical quality,

quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up, as appropriate.

- In 2020, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives like member outreach, provider education and outreach, incentives, educational materials, etc.
- The committee also reviewed and approved the policies and procedures as they were presented to the committee throughout 2020.
- The committee reviewed and provided feedback on key reports: annual analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); access to care; complaints and appeals; etc. Part of the feedback included specific actions that CalOptima could take to improve performance.
- The committee also received quarterly reports from the CPRC, UMC, MEMX, GARS, and WCM CAC. These reports were summarized and presented to the QAC quarterly in 2020.

Assessment of QI Staff and Resources

CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI program. In 2020, there were six additions to the QI department staff to support upcoming changes to the DHCS requirements for Facility Site Review as well as support staff for Potential Quality Issue (PQI) reviews. The QI department also received support from other key departments within the organization including, but not limited to, the following:

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

Review of System Resources

CalOptima has dedicated significant resources to ensuring they have adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima has the capability to generate quality reports, gaps in care reports, physician feedback reports, and other relevant reports needed in the QI program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts that can support the reporting needs of the organization.

Overall Assessment of Program Structure

At the current time, CalOptima has adequate staffing and resources required to meet the needs of the QI program in addition to organizational program requirements. However, in 2021 it may need reallocating resources to address initiatives aimed at improving Member Experience especially timely access to care. CalOptima will continue to evaluate the needs of the program through the Work Plan on a quarterly basis and add staffing and additional resources, as needed to supplement the QI department. The organization receives adequate feedback from its community practitioners in

the development and implementation of the QI initiatives and programs through the different committees. CalOptima continues to have significant participation from the Medical Directors in the development and implementation of clinical initiatives and programs throughout the year. The Medical Director(s) and QI Directors report the information back up to Senior Leadership.

SECTION 2: QUALITY & SAFETY OF CLINICAL CARE

HEDIS Overview

CalOptima annually reports HEDIS for all lines of business (LOB). HEDIS enables "apples to apples" comparison of health plan care across six domains of care:

1. **Prevention**
2. **Access and Availability of Care**
3. **Utilization**
4. **Member Experience (CAHPS)**
5. **Health Plan Descriptive Information (such as membership, language and ethnicity of membership)**
6. **New measures using Electronic Clinical Data Sources (Adult Immunization Status, Prenatal Immunization Status and Depression Screening)**

These results are annually audited by certified HEDIS Compliance Auditors. All measures fully passed audit which gives CalOptima confidence in the reliability of the results which are used to inform our QI Program and initiatives.

These clinical quality measures are used to evaluate multiple aspects of patient care including preventive care, coordination of care, patient safety, and management of chronic conditions.

Overall Performance Highlights

- Medi-Cal
  - In 2019, the MPL for California Medicaid plans was raised from the 25th to the 50th National Medicaid percentile. CalOptima achieved the new MPL for all measures in measurement year 2019.
  - Several measures showed statistically significant improvement from the prior year. Examples include Well-Child Visits for 15 months, Prenatal and Postpartum Care, Adolescent Immunizations, and Use of Opioids from Multiple Providers. CalOptima had 69% of measures at the National Medicaid 50th percentile or higher.
  - P4V program measures showed improvement, but several are still below the 50th percentile.
  - Based on the review of rates, several measures were identified as an opportunity for improvement including asthma medication ratio, lead screening in children, and follow-up care for Children prescribed ADHD medication. These measures will be monitored in the 2021 QI Work Plan.

Key Measures for Medi-Cal

Focus on new MCAS measure set required by DHCS

Measures in red indicate a decrease from MY2019 performance

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019

Lead Screening in Children	90th	75th
Asthma Medication Ratio	75th	50th
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	50th	25th

Key Measures for OneCare Connect (OCC)
Measures targeted for improvement are key metrics below 3 Stars or the National Medicare 50th percentile

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Care for Older Adults (Functional Status Assessment)	2 Star	2 Star
Follow-Up After Hospitalization for Mental Illness (OCC Quality Withhold)	25th	25th
Plan All-Cause Readmissions ages 65+ (OCC Quality Withhold)	1 Star	1 Star

Key Measures for OneCare (OC)

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Care for Older Adults (Functional Status Assessment)	3 Star	2 Star
Plan All Cause Readmissions	1 Star	2 Star
Diabetes Eye Exams	4 Star	2 Star

Evaluation of 2020 Priority Initiatives

CalOptima Homeless Health Initiative

In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 through 2020, for the Clinical Field Team (CFT) and Community Health Centers (CHCs). In addition to providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots, telehealth visits were added due to the COVID-19 pandemic. The CFT received 801 calls from CalOptima's Homeless Response Team, which yielded 686 members being treated, of which 439 were CalOptima members. There have also been 138 referrals to recuperative care.

Since implementation, Homeless Clinical Access Program (HCAP) has onboarded nine community health centers of which seven are still actively participating. Since August 2019, HCAP has been in the field for over 1,500 hours, paid out $300K in provider incentives and has treated 1,228 homeless participants (CalOptima and non-CalOptima members).

Next steps include assessing COVID-19 impacts, determining ongoing needs and evaluation of data and outcomes.

P4V Program

CalOptima implemented a comprehensive HN P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The comprehensive P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board. Annually, the CalOptima staff conducts a review of the current measures and their performance over time.

Based on a 2018 retrospective longitudinal QI performance review, although CalOptima consistently met the MPL, overall quality performance trends have been flat over the past five years. This trend is

very consistent with the California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009–2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, 59% remained unchanged or declined. CalOptima's HNs provided feedback including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data.

Based on the feedback, a new methodology has been adopted for MY2020–2021, which aims for greater transparency, consistency, and administrative simplification. The new HN Quality Rating (HNQR) methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, CMS Star Rating Status, newly required DHCS MCAS and/or overall NCQA Health Plan Rating. This new methodology was approved by the CalOptima Board of Directors in February 2020. The new methodology also received approval from the CalOptima Board of Directors to double the per member per month (PMPM) incentive to network providers and HNs for the P4V program.

Evaluation of Initiatives for Specific HEDIS Measures

This evaluation of quality initiatives focuses on activities performed in 2019 on priority measures identified in the QI Work Plan and to impact the HEDIS 2020 (MY2019) rates. This evaluation also describes current 2020 quality initiatives and gives preliminary insight as to barriers and lessons learned that inform the development of the 2021 QI Work Plan.

Please note: All HEDIS results equate to the prior MY, e.g., HEDIS 2020 refers to MY2019. All graphs reflecting HEDIS 2020 Results show a trend analysis for MY2017–2019.

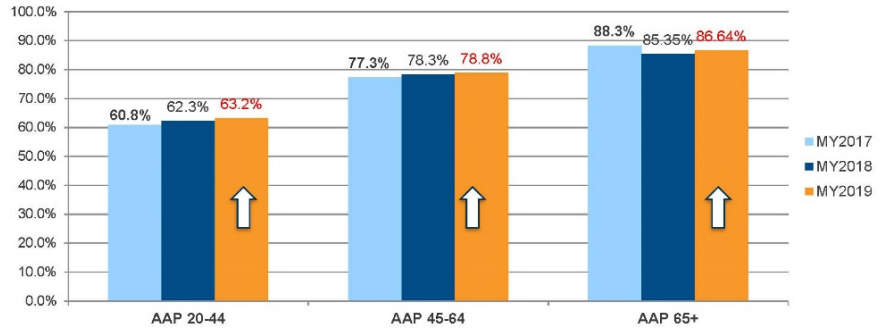
Kaiser members were excluded from this program evaluation since the QI Program and activities are fully delegated to Kaiser, thus they were not included in CalOptima quality initiatives. Please note, however, that Kaiser members *are* included as part of the HEDIS 2020 final rate calculations.

Adult's Access to Preventive/Ambulatory Services (AAP): Medi-Cal

The table below shows a trend analysis for Medi-Cal Adult's Access to Preventive/Ambulatory Services (AAP) for the MY 2017–2019. The rates have steadily increased for AAP the past three years. However, a decline is anticipated in the 2020 MY rates due to observed dip in preventive care and well care visits during the COVID-19 pandemic. This measure is incentivized in our P4V program and has helped the improvement of this measure.

AAP Table: Trending HEDIS Rates MY2017–2019 Results: Medi-Cal

HEDIS 2020 Results: Medi-Cal
Annual Visits to PCP's



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Services (AAP) 20-44	78.63%	82.36%	85.30%	71.59%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 45-64	86.32%	88.84%	90.88%	81.68%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 65+	88.07%	92.07%	94.70%	88.07%	P4V

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

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26

2019 Adult's AAP Initiatives: Medi-Cal

- Implemented HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness. This program is monitored by the Program Manager, and data collection is tracked and monitored monthly. It is important to continue implementing the program activities as it is still in the infancy stage.
- Promoted the preventive health care services such as breast cancer screening, cervical cancer screening and colorectal cancer screenings for the appropriate age groups and populations. These activities subsequently impacted the AAP measure by engaging members to access health care services. For more information, refer to the breast cancer screening, cervical cancer screening and colorectal cancer screening sections.

2020 Adult's AAP Initiatives: Medi-Cal

- Implemented HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.
- Promotion of preventive health care services such as breast cancer screening, cervical cancer screening and colorectal cancer screenings for the appropriate age groups and populations. These activities subsequently impacted the AAP measure.

Barriers

- Due to the COVID-19 pandemic, there was a drop in well-care visits during March–August 2020. CalOptima's June 2020 prospective rate reports show a decline when compared to the same time last year. The community is reluctant to go in for their routine well-care visits and immunizations due to COVID-19. CalOptima will continue our efforts to promote well-care visits during this time.

Opportunities for Improvement

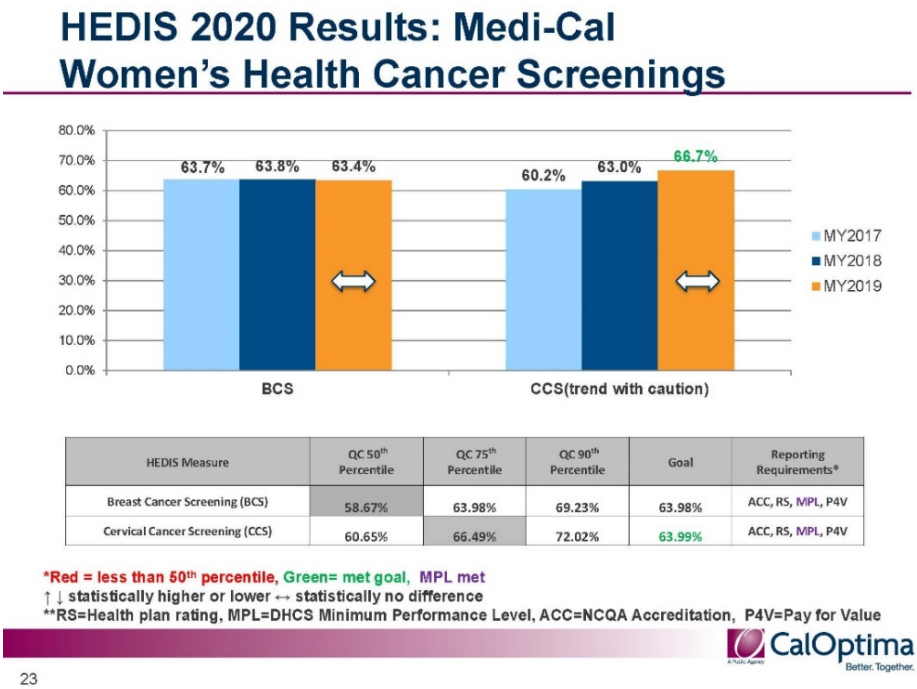
- Continue to promote appropriate well-care visits and immunizations for adults during this time.
- Continue the HCAP services for person experiencing homelessness in Orange County.
- Continue with implementing appropriate member and provider incentive (the term "health reward" is used interchangeably) programs for 2021 to increase preventive health care screenings and tests.
- Keep as a QI Work Plan priority due to catch up that will need to occur due to COVID-19.
- Consider developing a general well care visit member incentive or anticipatory guidance to promote preventative visits in light of member hesitation due to COVID-19.
- Leverage alternative member outreach modality such as mobile text messaging to promote well care visits safely.

Preventive Health Screenings (BCS/CCS/COL)

Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS): Medi-Cal

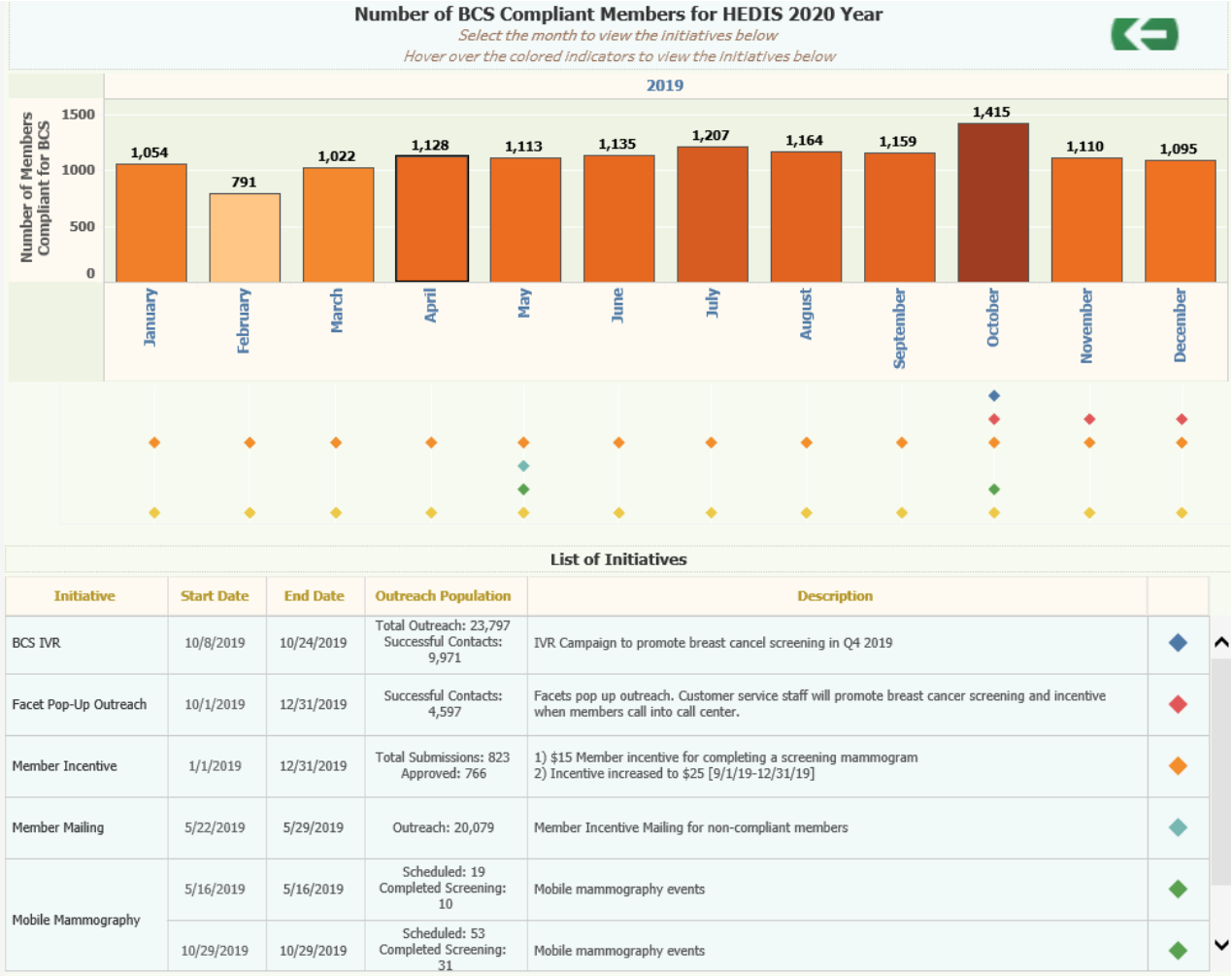
In 2020, CalOptima had initiatives for BCS and CCS cancer screenings. The table below shows a trend analysis of Medi-Cal BCS and CCS for the last three MY2017–2019. The rates have been steady for BCS but show improvement for CCS. However, we anticipate some decline in the 2020 MY rates due to the COVID-19 pandemic.

BCS/CCS Table 1: Trending HEDIS Rates MY2017-2019 Results: Medi-Cal



BCS Table 2: Impact of BCS Targeted Interventions on HEDIS 2020 Year: Medi-Cal

The table below shows the number of unique members who received a BCS mammogram month by month and the impact of interventions throughout the year. While the rate remained steady throughout the year, the month with the highest jump in BCS screenings occurred in October 2019, right after the amount of the member incentive raised from $15 to $25. In addition, IVR outreach, FACETS member outreach and mobile mammography initiatives all took place in October 2019. Breast Cancer Awareness month also in October.



2019 BCS Initiatives: Medi-Cal

1. BCS Member Incentive 01/01/2018–12/31/2019

A. Description

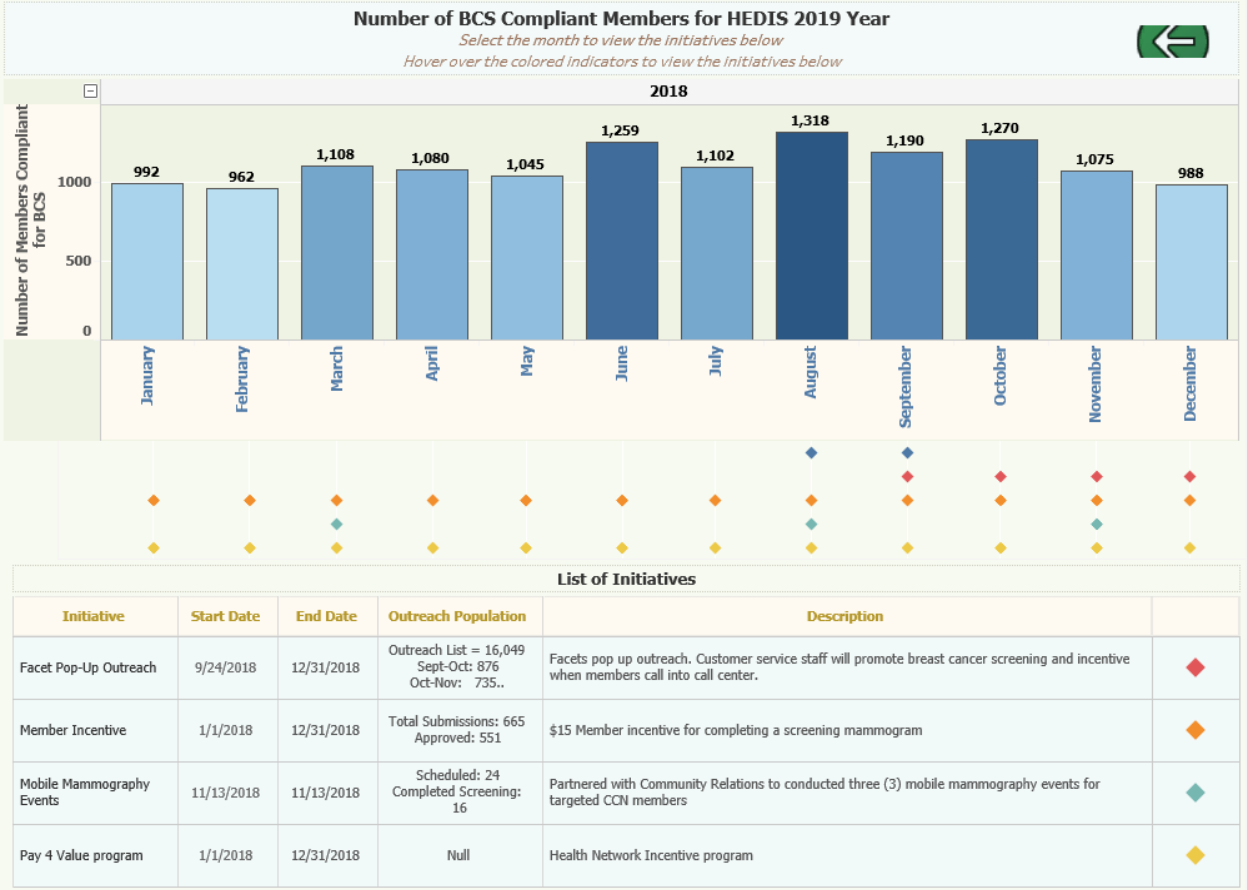
In August 2018, 16,340 eligible Medi-Cal members ages 50–74 were mailed a BCS incentive form for a $15 gift card. In May 2019, 20,079 CalOptima Medi-Cal members ages 50–74 identified as needing a screening mammogram completed before 12/31/2019, were mailed a $15 incentive form in May 2019. The incentive amount was changed in September 2019 from $15 to $25. The mailing was not repeated due to limited budget for mailing; however, members were made aware of the incentive via IVR robocall campaign.

BCS Table 3: Breast Cancer Screening Incentive Mailing MY2018–MY2019

BCS Incentive Forms	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2018	16,340	626	482	32,059	1.50%
2019	20,079	753	594	32,940	1.80%

NOTE: The HEDIS denominator was used to calculate the participation rate.

BCS Table 4: The table below shows the BCS initiatives for the HEDIS 2019 (MY2018) year. The data shows a steady number of members compliant for BCS throughout the year with only a slight rise in August 2018 when the BCS member incentive form was mailed to eligible members.



List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Facet Pop-Up Outreach	9/24/2018	12/31/2018	Outreach List = 16,049 Sept-Oct: 876 Oct-Nov: 735..	Facets pop up outreach. Customer service staff will promote breast cancer screening and incentive when members call into call center.
Member Incentive	1/1/2018	12/31/2018	Total Submissions: 665 Approved: 551	$15 Member incentive for completing a screening mammogram
Mobile Mammography Events	11/13/2018	11/13/2018	Scheduled: 24 Completed Screening: 16	Partnered with Community Relations to conducted three (3) mobile mammography events for targeted CCN members
Pay 4 Value program	1/1/2018	12/31/2018	Null	Health Network Incentive program

B. Analysis

1. In 2018, of the 16,340 members mailed the incentive form in August 2018, 14,521 remained in the denominator for the HEDIS 2019 BCS measure. Of those, 1,603 members completed a BCS after the mail drop date with a rate of 5.00% (1,603/32,059). Of the 626 BCS incentive form submissions, 482 BCS incentive form submissions remained in the BCS measure denominator. The incentive participation rate for the HEDIS 2019 BCS measure was 1.50% (482/32,059).
2. In 2019, of the 20,079 members mailed the incentive form in May 2019, 16,823 were part of the HEDIS denominator for the HEDIS 2020 BCS measure. Of those mailed the incentive a total of 753 BCS incentive forms were received, 594 members were in the BCS measure denominator. The incentive participation rate for the HEDIS 2020 BCS measures was 1.8% (594/32,940). Of the 594 HEDIS eligible forms there were 493 forms date of service (DOS) matched our claims/encounters data while 101 forms DOS did not match with a rate of 83.00%.
3. Although the participation rate increased from MY2018 to MY2019, it was minimal. Considering there was no additional interventions, other than the one-time mailing, and very little promotion, the low participation rate was expected.

C. Barriers

1. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until the end of Q1 every year. Additionally, it is unknown which percentage of mail is returned due to wrong addresses.
2. The member incentive form requires a signed/stamped attestation by the primary care provider (PCP) or imaging center. This may prevent some members from participating in the BCS incentive, on top of a perceived aversion and negative perception of the mammogram experience.
3. The low dollar amount of the incentive may not have been a big enough incentive, therefore the adjustment from $15 to $25 in September 2019.
4. Incentive was not communicated effectively to members or providers resulting in low incentive participation.
5. The merging of multiple interventions in October 2019 makes it unclear which intervention had the most impact.

D. Opportunity for Improvement

1. Due to the late September 2019 change of the dollar amount of the incentive, continue the BCS incentive through 2020 and 2021 to allow more time for members to be aware of the incentive programs offered.
2. Enhance the BCS member by utilizing multiple modes of communication via website, direct mailings, IVR calls and mobile text messaging and more direct collaboration with CCN providers and HN quality teams.
3. Messaging can be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race. Utilize Gaps in Care outreach nurses.

2. BCS FACETS Member Outreach 10/01/2019–12/31/2019

A. Description

Target CalOptima Medi-Cal members ages 50–74 that were non-compliant for BCS that have placed an inbound call to CalOptima for another need. Customer Service staff had an opportunity to promote the importance of BCS to a captive audience/member that need to complete BCS. Also, members notified of the incentive opportunity available for completing a screening mammogram.

B. Analysis

1. Customer Service was able to deliver the FACETS pop-up message to 4,597 non-compliant members. Of the 4,597 members that were targeted 1,920 members were in the denominator for the HEDIS 2020 BCS measure.
2. The rate of members that received the message for HEDIS 2020 BCS measure was 5.83% (1,920/32,940). Of the members who received the FACETS pop-up message, 133 members completed a BCS after receiving FACETS pop-up message with a rate of 0.40% (133/32,940).

C. Barriers

1. This intervention is only available to members who called into the Customer Service line and likely already proactive about their health. It is uncertain if the FACETS pop-up message was the only reason member would complete their BCS.

D. Opportunities for Improvement

1. Continue BCS FACETS member outreach as part of a more robust member communication/touchpoint plan.
2. Expand the duration of the BCS FACETS member outreach or also conduct initiative earlier in the MY as well.

3. **BCS IVR Outreach 10/08/2019–10/24/2019**
   A. **Description**
   Member outreach campaign targeted eligible CalOptima Medi-Cal members ages 50-74 that were non-compliant for BCS to encourage completion of a BCS.

   B. **Findings**

BCS Table 5: This table shows the results of non-compliant members that were targeted for the BCS IVR call campaign.

2019 BCS IVR Outreach	Successful IVR Calls	Unsuccessful IVR Calls	Total IVR Calls	Rate of Successful IVR Calls
BCS IVR Call Campaign	9,971	13,826	23,797	41.90%
HEDIS 2020 BCS Measure	1,299	11,870	13,169	9.86%

   C. **Analysis**
      1. Of the 23,797 total IVR calls made, 9,971 of the calls were listened to or completed, a rate of 41.90% (9971/23797). Of the 23,797 members that were targeted 13,169 were in the denominator for the HEDIS 2020 BCS measure. The rate of successful IVR calls for the HEDIS 2020 BCS measure was 9.86% (1,299/13,169).

   D. **Barriers**
      1. Unsuccessful IVR call was largely due to the member hanging up the call before the message was completed, no answer/busy and bad number.

   E. **Opportunities for Improvement**
      1. Expand member outreach modality beyond BCS IVR call campaign as the only method to notify members when they are due for BCS.
      2. Continue BCS IVR call campaign as part of a more robust member communication/touchpoint plan.
      3. Re-design BCS IVR call campaign to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
      4. Make use of mobile text messaging and IVR campaigns in 2021.

4. **Breast Cancer Screening (BCS) Mobile Mammography 05/16/2019; 10/29/2019**
   A. **Description:** Targeted eligible CCN Medi-Cal members ages 50–74 to complete BCS at a planned mobile mammography event at two locations. Members that attended and completed BCS received $20 gift card.
      1. Mobile mammography event held on 05/16/2019 at the Nhan Hoa Comprehensive Health Care Clinic. Mobile mammography event held 10/29/2019 at the CalOptima Westminster Satellite Office.
      2. BCS mobile mammography data was used to evaluate how many members completed BCS at one of the mobile mammography events and were included in the denominator for the HEDIS 2020 BCS measure.

B. Findings

BCS Table 6: This table shows the results of non-compliant members that were targeted for BCS mobile mammography.

BCS Mobile Mammography	Scheduled	Completed BCS Screening	HEDIS 2020 Denominator	Completed BCS Screening
BSC Mobile Mammography (Combined events)	72	41	--	--
HEDIS 2020 BCS Measure	53	28	32,940	0.09%

C. Analysis

1. Of the 72 members that were scheduled, 53 members were in the denominator for the HEDIS 2020 BCS measure. Of the 72 scheduled, 41 completed the screening. Of the 53 in the denominator, only 28 completed the screening. The rate of members that completed BCS through the event against the overall denominator for the HEDIS 2020 BCS measure was 0.09% (28/32,940).

D. Barriers

1. 43% of the scheduled members did not attend the event. The intervention is resource intensive and takes extensive planning across internal departments. Due to contractual limitations with the mobile mammography vendor, the event could only accommodate a relatively small volume of members.
2. Qualitative feedback from attendees showed significant value of bringing the service out to the community albeit it being resource intensive to support a traditionally difficult-to-reach portion of the membership.

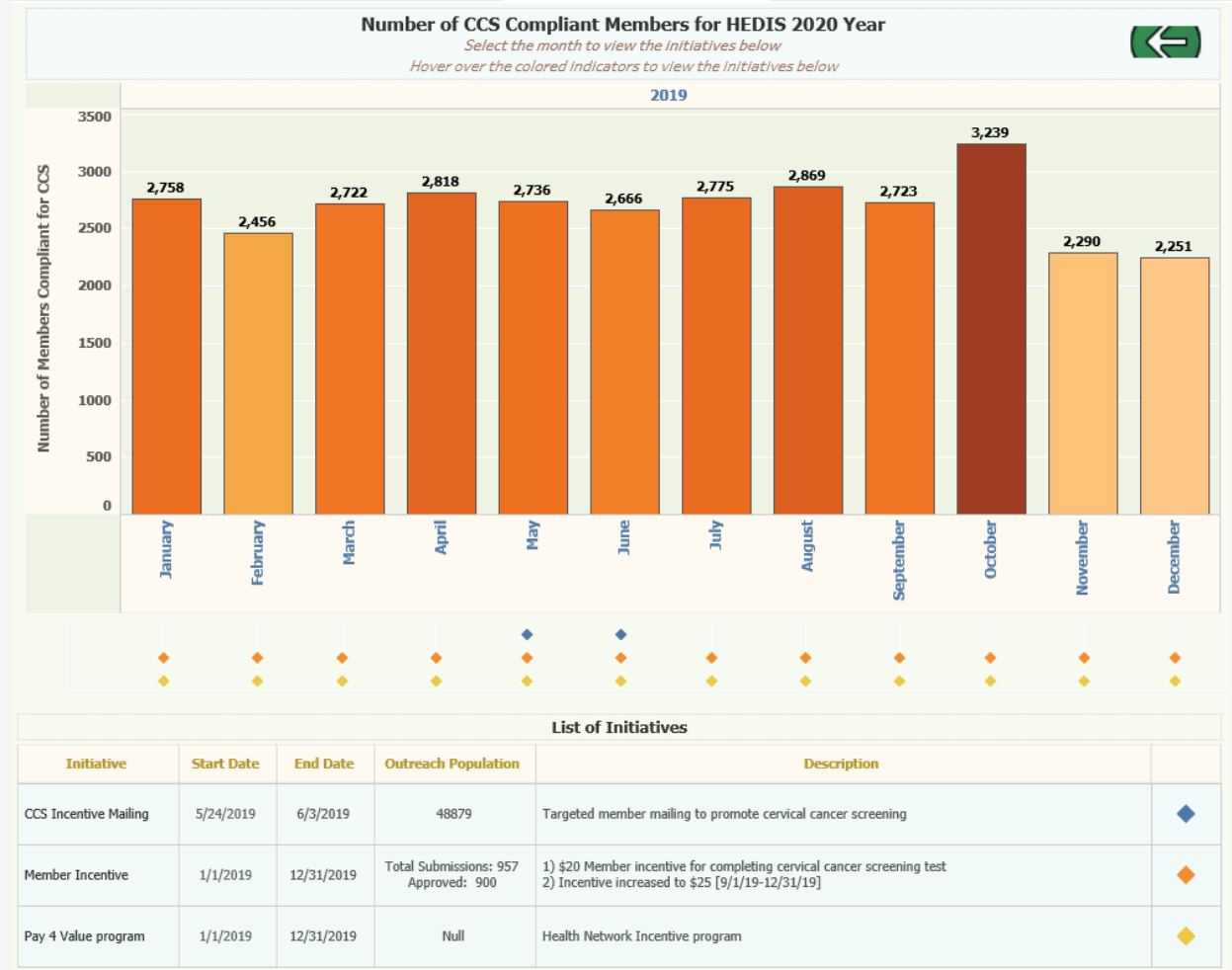
E. Opportunities for Improvement

1. Explore a less resource intensive mechanism to solicit and include qualitative feedback from attendees
2. Adapt mobile mammography events to reach greater volume of members likely to engage in geographic locations or places of gathering, possibly leveraging CalOptima's nearby imaging centers that can accommodate higher volume.

2019 Cervical Cancer Screening Initiatives: Medi-Cal

CCS Table 2: Impact of CCS Targeted Interventions on HEDIS 2020 Rates: Medi-Cal

The table below shows the number of unique members who received a pap test and the impact of interventions throughout the year. The data shows a steady number of members compliant for CCS throughout the year. The highest number of cervical screenings occurred in October 2019 when the CCS member incentive dollar amount increased from $20 to $25.



1. Cervical Cancer Screening (CCS) Member Incentive 01/01/2018–12/31/2019

A. Description

In August 2018, 66,675 eligible Medi-Cal members ages 21–64 were mailed a CCS incentive form for $20 gift card. In May 2019, 48,879 CalOptima Medi-Cal members ages 21–64 identified as needing a cervical cancer screening or pap test completed before 12/31/2019 were mailed a $20 incentive form. The incentive amount was changed in September 2019 to $25. The mailing was not repeated due to limited budget for an additional mailing; however, members were made aware of the incentive via IVR robocall campaign.

B. Findings

CCS Table 4: Cervical Cancer Screening Incentive Mailing MY2018–MY2019

CCS Incentive Forms	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2018	66,675	745	699	119,220	0.57%
2019	48,879	963	705	117,422	0.60%

NOTE: The HEDIS denominator was used to calculate the participation rate.

C. Analysis

1. In 2018, of the 66,675 members mailed the incentive form in August 2018, 56,767 remained in the denominator for the HEDIS 2019 CCS measure. 4,618 members completed a CCS after the mail drop date with a rate of 3.87% (4,618/119,220). Of the 745 CCS incentive form submissions, 699 CCS incentive form submissions remained in the CCS measure denominator. The incentive participation rate for the HEDIS 2019 CCS measure was 0.57% (699/119,220).
2 In 2019, of the 48,879 members mailed the incentive form in May 2019, 36,548 were part of the HEDIS denominator for the HEDIS 2020 CCS measure. Of those mailed the incentive, 3873 completed a screening after the mail drop with a rate of 3.30% (3,873/117,422). Of a total of 963 CCS incentive forms received, 705 members were in the CCS measure denominator. The incentive participation rate for the HEDIS 2020 CCS measures was 0.60% (705/117,422). Of the 705 HEDIS eligible forms there were 607 forms DOS matched our claims/encounters data while 98 forms DOS did not match with a rate of 86.10%.
3. Although the participation rate increased from MY2018 to MY2019, it was minimal. Considering there was no additional interventions, other than the one-time mailing, and very little promotion, the low participation rate was expected.

D. Barriers

1. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until Q2 every year. It is unknown which percentage of mail is returned due to wrong addresses as well.
2. The member incentive form requires a signed/stamped attestation by the PCP or imaging center. This may prevent some members from participating in the BCS incentive on top of a perceived aversion and negative perception of the mammogram experience.
3. The low dollar amount of the incentive may not have been a big enough incentive, therefore the adjustment from $20 to $25 in September 2019.
4. Incentive was not communicated effectively to members or providers resulting in low incentive participation.
5. The merging of multiple interventions in October 2019 makes it unclear which intervention had the most impact. A 2020 mailing to all members due for a pap test in 2020 was delayed from the original intended date in March 2020 to August 2020 due to deliberate delays in having members come in during the height of the COVID-19 pandemic.

E. Opportunities for Improvement

1. Continue the CCS incentive through 2020 and 2021 to allow more time for members to be aware of the incentive programs offered.
2. Expand member outreach beyond CCS member mailing. Heightened promotion of the CCS incentive utilizing multiple modes of communication via website, direct mailings, IVR calls and mobile text messaging and more direct collaboration with CCN providers and HN quality teams is recommended in 2020 and 2021 to see the impact and trend of incentive enhancements.
3. Redesign messaging to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
4. Utilize Gaps in Care outreach nurses.

2020 Breast Cancer Screening and Cervical Cancer Screening Initiatives: Medi-Cal

- BCS and CCS incentive mailing originally scheduled for March 2020 was delayed and mailed in August 2020 to all eligible members who were due for a BCS or CCS. To address concerns about urging preventative screenings raised by HNs, a COVID-19 disclaimer was added to all mailings encouraging members to have the discussion about any risks and to determine the best care plan for each member weighing the risk against the benefits.
- Continued monitoring and tracking member incentive for both BCS and CCS screening measures.
- Collaborate and coordinate outreach efforts with HN quality teams on call, IVR and mailed campaigns. Some HNs agreed to promote CalOptima incentives.
- Promote member incentives through website, HN and provider update faxes and communications, incentive posters for medical offices.
- IVR campaign for the CCS population in January 2020 to align with the national monthly observances.

Barriers

- Due to the COVID-19 pandemic, preventive care visits began declining in March 2020. CalOptima's June 2020 prospective rate reports show a decline when compared to the same time last year. The community was reluctant to go in for their preventive care screenings due to COVID-19.
- Members are afraid of the procedure itself and other members are afraid of the result. Both barriers are related to member understanding of the tests and treatment options available.
- Incentives were not loaded to the CalOptima website until March 2020 due to design and approval delays.
- Incentives were not mailed to target populations in March 2020 as scheduled due to COVID-19 and were delayed until August 2020.
- BCS IVR campaign scheduled for May was put on hold due to surge in COVID-19 cases, and the need to adjust messaging to include safety precautions in light of the pandemic.

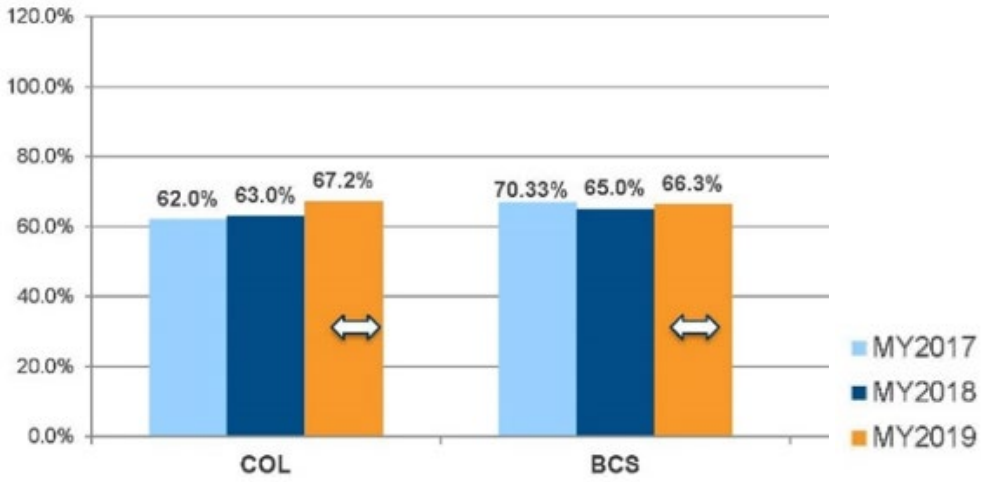
Opportunities for Improvement

- Despite negligible improvements in incentive participation rates for BCS and CCS, considering the minimal amount of outreach in MY2018 and MY2019, and due to the late nature of the upgrade for both incentives to $25, the incentive program should run through 2020-2021 to see how wider marketing and promotion in working directly with HNs and high volume providers for both incentives may impact utilization and rates.
- Retain these measures on the 2021 QI Work Plan and continue to focus on preventive care screenings including BCS and CCS to address expected dips in utilization through multi-media awareness messaging and communications.
- Expand messaging and promotion of $25 incentives for the BCS and CCS screenings appealing to the importance of not delaying due to COVID-19 and the financial benefit of the $25 gift card.

Breast Cancer Screening (BCS) and Colorectal Cancer Screening (COL): OC and OCC

The table below shows a trend analysis for OCC BCS and COL for MY2017-2019. The rates have slightly increased for BCS from 2018 to 2019. The rates for COL have gradually increased from 2017–2019. However, we anticipate some decline in the 2020 MY rates due to the COVID-19 pandemic.

HEDIS 2020 Results: OneCare Connect Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	62%	73%	80%	73%	Star, P4V
Breast Cancer Screening (BCS)	66%	76%	83%	66%	Star, P4V

2019 Breast Cancer Screening and Colorectal Cancer Screening Initiatives: OC and OCC

- CalOptima offered a $25 breast screening incentive and a $50 colorectal cancer screening incentive as two new health rewards (health reward and incentive are used interchangeably) to the Medicare population late in September 2019. To qualify for the BCS incentive program, a member must complete a screening mammography in 2019 in order to receive a $25 health reward. To qualify for the COL incentive program, a member must complete either a sigmoidoscopy or colonoscopy in 2019 in order to receive a $50 health reward. The response rates for these programs was close to zero due to a late launch in the year and no official mailing sent to eligible members due to delays with form graphic design and approval through CMS. The forms were not made available on the CalOptima website until March 2020.

2020 Breast Cancer Screening and Colorectal Cancer Screening Initiatives: OC and OCC

Continued monitoring and tracking member incentive for both screening measures.

- Official launch of new $25 OC/OCC breast cancer screening and $50 OC/OCC COL member incentives in January 2020 with HN and CCN provider notifications.
- Fillable PDF forms posted on the CalOptima website in March 2020.
- Incentive article in OCC member newsletter in Summer 2020 issue.

Barriers

- Due to the COVID-19 pandemic, there was a drop in preventive care screenings starting March 2020. CalOptima's 2020 rate reports continue to show a decline when compared to the same time last year. The community is reluctant to go in for their preventive care screenings due to COVID-19.

- Members are afraid to know the result of the tests and avoid getting screened because of that fear.
- COVID-19 added to another level of fear to get preventive care services as members have stayed away from any kind of clinic visits.
- IVR campaigns were put on hold due to a surge in COVID-19 cases to prioritize pandemic safety precautions.

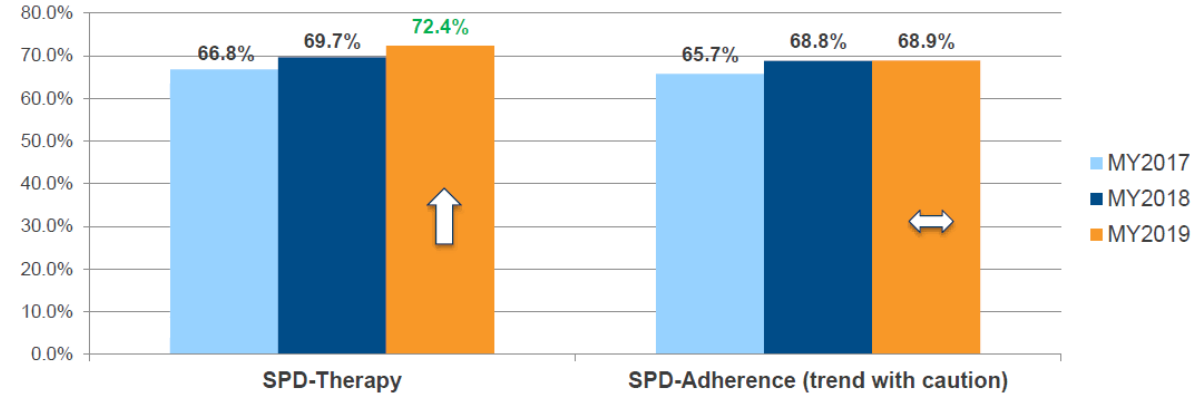
Opportunities for Improvement

- Continue both member incentives for the OC and OCC populations.
- Due to new barriers experienced by COVID-19 this year, CalOptima will retain both BCS and COL measures on the 2021 QI workplan and continue to focus on preventive care screenings to address expected dips in utilization through multi-media awareness messaging and communications.
- Expand messaging and promotion of both screening incentives appealing to the importance of not delaying due to COVID-19 and the financial benefit of the gift cards.

Statin Therapy for Patients with Diabetes (SPD)

The table below shows a trend analysis for Medi-Cal SPD measure for MY2017–2019. SPD-therapy sub measure met the MPL goal for MY2019 reaching the 90th percentile MPL. Although we did not meet goal for the SPD-adherence sub measure MY2019, we did achieve the 75th percentile satisfying the MPL. However, some decline is anticipated in the 2020 MY rates due to the COVID-19 pandemic.

SPD Table 1: HEDIS Trending Rates 2017–2019



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.65%	67.19%	70.19%	70.19%	ACC, RS
Statin Therapy for Patients with Diabetes (SPD) - adherence	59.11%	64.62%	72.03%	71.00%	ACC, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

2020 Statin Therapy for Patients with Diabetes (SPD) Initiatives: Medi-Cal, OC and OCC

1. Pharmacy Department SPD Provider Faxes 2019-2020

A. Description

CalOptima's Pharmacy department sent a list of members to providers for member outreach in order to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggested non-adherence.

SPD Table 2a and b: Pharmacy Department SPD Provider Faxes 2019–2020

QTR	Date of Fax	Total Member Count Included in Fax	# of Included MCAL Members	# of Included OC Members	# of Included OCC Members
1Q19	3/27/19	7,905	7,125	69	711
2Q19	5/23/19	9,292	8,333	94	865
3Q19	8/16/19	7360	6,429	115	816
4Q19	11/20/19	8,603	8,584	19	726

Pharmacy Department SPD Provider Faxes 2020												
Number of Members Faxed to Providers												
	Quarter 1 2020				Quarter 2 2020				Quarter 3 2020			
Sub measure	MCAL	OC	OCC	Total	MCAL	OC	OCC	Total	MCAL	OC	OCC	Total
Statin Needed	3,176	42	397	3,615	4,166	56	516	4,738	3,861	53	447	4,361
Statin Non-Adherence	2,489	22	266	2,777	1,823	13	206	2,042	2,225	35	297	2,557
Total	5,665	64	663	6,392	5,989	69	722	6,780	6,086	88	744	6,918

2. Quarterly SPD Member Mailings

A. Description

In an effort to reinforce the SPD provider faxes, a quarterly complementary member mailing was created to educate members with diabetes who are not on a statin medication or non-adherent to have the conversation with their PCP about whether a statin was right for them to reduce cardiovascular risk as a precautionary safety measure. The mailing included this message and information about statin medications. PHM sent quarterly mailings to members to improve SPD Statin Therapy and Statin Adherence measures. Identified members were either not currently on a statin medication or had an adherence rate <80% of their statin medication. Since 2019 was a planning year for this initiative, the data was finalized in November 2019 The mailer first dropped in Q1 2020 and included a cover letter prompting

the member to ask their doctor if a statin medication is right for them along with a member material about statin medication.

SPD Table 3: SPD Quarterly Member Mailings

	SPD Member Quarterly Mailings					
	Q1 2020			Q2 2020		
LOB	**Targeted Non-Compliant Members Sent Letter**	**Compliant Members After Mailing**	**Compliance Rate by Next QTR**	**Targeted Non-Compliant Members Sent Letter**	**Compliant Members After Mailing**	**Compliance Rate by Next QTR**
OC	40	32	80%	8	5	63%
OCC	276	146	53%	125	46	37%
Medi-Cal	2334	1006	43%	1007	278	28%
Total	**2650**	**1184**	45%	**1140**	**329**	29%

B. Analysis

- In Q1 2020, the compliance rate by next quarter was 80% for OC, 53% for OCC and 43% for Medi-Cal. Overall, there was a 45% compliance rate across the lines of business, by the next quarter. In Q2 2020, the compliance rate by next quarter was 63% for OC, 37% for OCC and 28% for MC and overall, we had a 29% compliance rate by the next quarter in Q2 2020. Compliance rates improved most significantly for OC members, likely because these members had greater medical needs and were more consistently under a physician's direct care.

C. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications with diabetes.

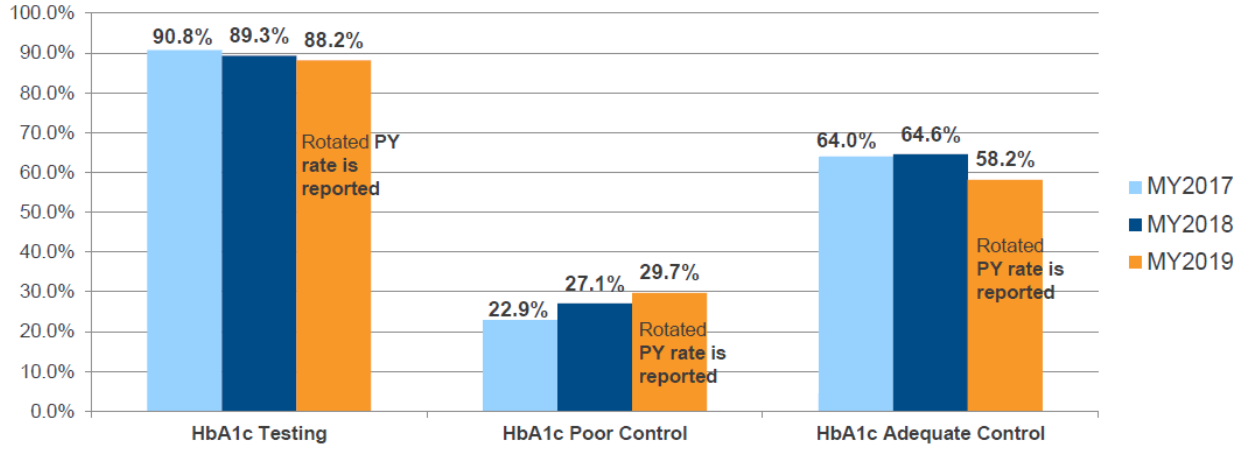
D. Opportunities for Improvement

1. Due to moderate success in affecting compliance, the quarterly faxes will continue to be sent to providers of their diabetic and quarterly member mailings to newly identified diabetic members who are not currently on a statin medication. The provide are an additional layer of support to other efforts to prevent cardiovascular risk among the diabetic population and promote safety.
2. Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
3. Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
4. Continue newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Comprehensive Diabetes Control (CDC): A1C Testing and Eye Exam

The table below shows the trend analysis for Medi-Cal Comprehensive Diabetes Care (CDC) HbA1c measure for the years 2017–2019. HbA1c Poor Control met the 75th percentile surpassing the MPL (lower is better). HbA1c Adequate Control sub measure met the 75th percentile.

CDC Table 1: HbA1cTesting and Control

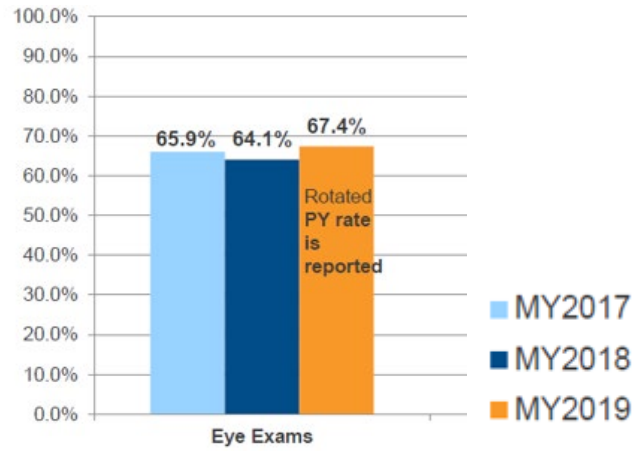


HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	88.55%	90.51%	92.94%	89.78%	MPL
HbA1c Poor Control (>9.0%) (Lower is better)	38.52%	32.85%	27.98%	27.98%	MPL
HbA1c Adequate Control (<8.0%) ++	50.97%	55.96%	60.77%	60.77%	ACC, RS, P4V

*Red = less 50th percentile, Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings
↑ ↓ statistically higher or lower ↔ statistically no difference
*RS=Health Plan Rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

CDC Table 2: Eye Exam

The table below shows the trend analysis for the Medi-Cal CDC Eye Exam measure for MY2017–2019. Eye Exam measure met the 50th percentile meeting the MPL.

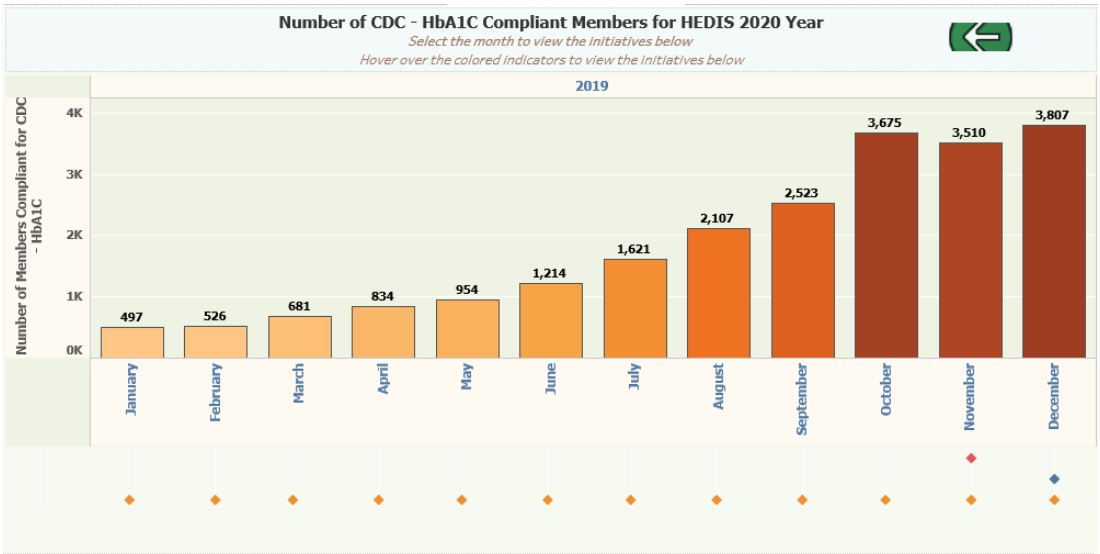


HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Eye Exams	57.88%	64.23%	68.61%	64.72%	ACC, RS, P4V

Back to Agenda

CDC Table 3: HbA1C Compliant Members for HEDIS 2020

The table below shows the HbA1C initiatives for the HEDIS 2020 (MY2019) year. The data shows a gradual increase month to month even more so for June 2019 to October 2019. A factor that could have contributed to this increase may have been the distribution of the member incentive in June 2019. A slight decrease occurred in November 2019. The HbA1c IVR campaign deployment in November 2019 as well as the implementation of the Diabetes Health Coaching initiative helped with increasing member compliance in December 2019.



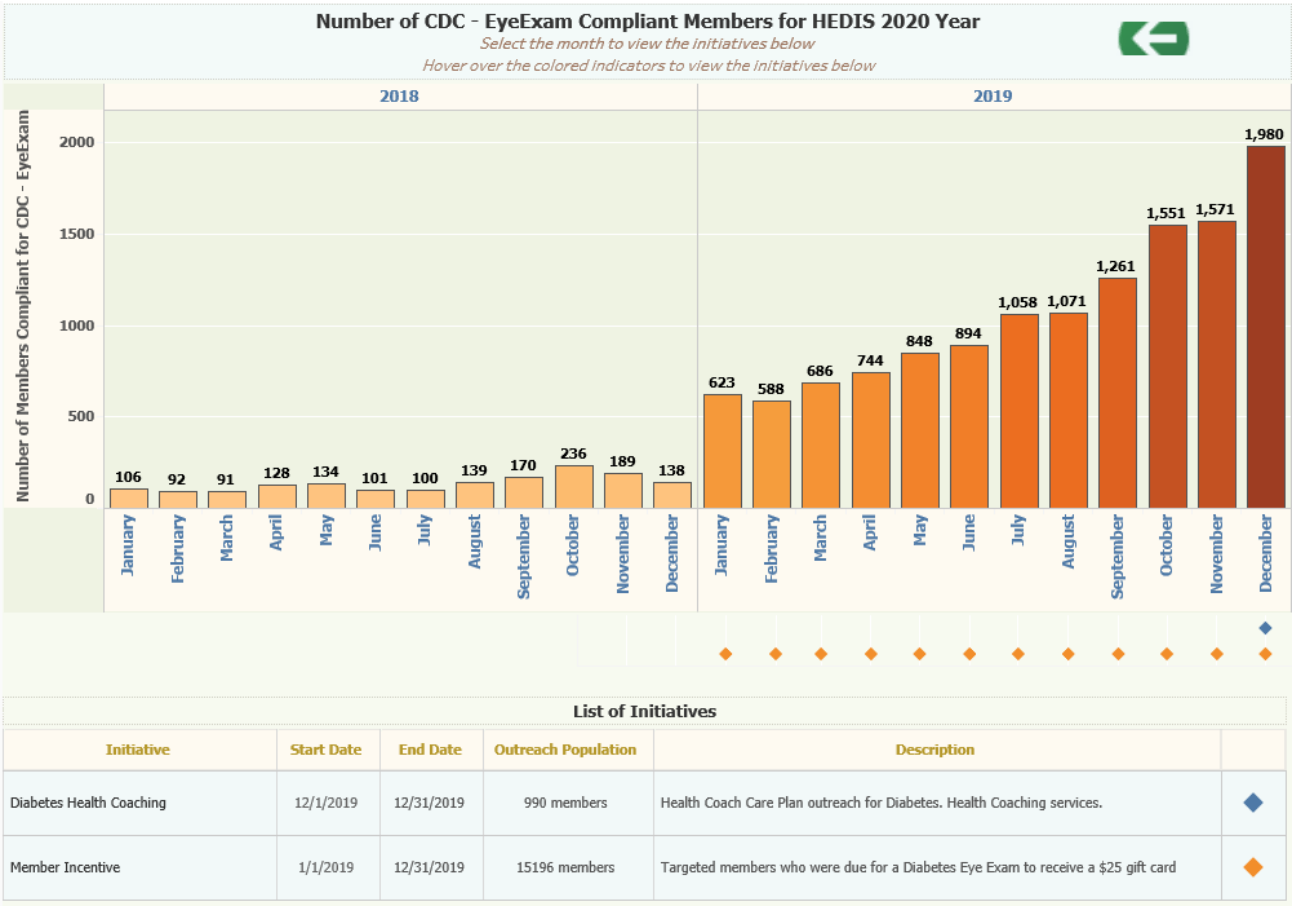
List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description	
A1c IVR campaign	11/1/2019	11/24/2019	29525 members	Outreach to diabetic members via robo calls and encourage them to see their provider	◆
Diabetes Health Coaching	12/1/2019	12/31/2019	990 members	Health Coach Care Plan outreach for Diabetes. Health Coaching services.	◆
Member Incentive	1/1/2019	12/31/2019	15196 members	Targeted members who were due for a HbA1c test to receive a $25 gift card	◆

CDC Table 4-Eye Exam Compliant Members for HEDIS 2020

The table below shows the Eye Exam initiatives for the HEDIS 2020 reporting year. It is split into two sections:

- The 2018 measurement year section contains the number of members that had a negative retinal or dilated eye exam (negative for retinopathy) which would count towards HEDIS 2020 reporting year.
- The 2019 measurement year section contains the numbers of members who had a diabetic retinal eye exam due to a date of service in 2019. The data shows a gradual increase month to month from January 2019 to December 2019. The data shows some increases month to month even more so for June 2019 to October 2019. A factor that could have contributed to this increase may have been the distribution of the member incentive in June 2019. The deployment of the Diabetes Health Coaching initiative also helped with increasing the figure in December 2019.



2019 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. **HbA1c IVR Campaign**
   A. **Description:** 55,578 eligible members without an HbA1c completed in the HEDIS 2020 Comprehensive Diabetes Care (CDC) HbA1c testing measure and Medicare LOBs alike were contacted through IVR campaign.

CDC Table 6: IVR calls for All LOBs

2019 A1C IVR Campaign				
LOB	**Successful IVR Calls**	**Unsuccessful IVR Calls**	**Total IVR Calls**	**Rate of successful IVR Calls**
Medi-Cal	17001	35101	52102	32.63%
OC	121	148	269	44.98%
OCC	1033	2174	3207	32.21%

Back to Agenda

B. Analysis

A successful call is defined as a completed call or message left on voicemail. Overall, there was a 32.63% successful IVR call rate for Medi-Cal. OC had a 44.98% successful IVR call rate. OCC had a 32.21% successful IVR call rate. Members were contacted telephonically via robocall with a message emphasizing the importance of scheduling an HbA1c test with their provider and using statin medication.

C. Barriers

Some barriers include unable to contact member, disconnected phone number, member hung up before the full message was received.

D. Opportunities for Improvement

1. Consider option for text message method for members with mobile cell phone numbers.
2. Increase effort to "clean up" incorrect mobile phone numbers for members.

2. HbA1c and Diabetic Eye Exam Member Incentives

A. Description

Although the diabetes HbA1c Testing and Eye Exam member incentive have been active since 2016, trend analysis of member incentive only included MY2018–MY2019 data due to unavailability of data beyond MY2018.

1. In August 2018, targeted eligible members that were non-compliant in the HEDIS 2019 CDC HbA1c testing (n=10,891) and CDC Eye Exam (n=15,605) measures were mailed both incentive forms for a $15 gift card.
2. In June 2019, targeted eligible members that were non-compliant in the HEDIS 2020 CDC HbA1c testing (n=15,196) and CDC Eye Exam (n=5466) measures were sent the HbA1c Test and/or diabetic eye exam member incentive forms for a $25 gift card. In addition to the member incentive forms, the members also received information on statin medicine and diabetes health coaching services. Population based on March 2019 data pull.

B. Findings

CDC Table 7: MY2018–MY2019 Direct Mail Member Incentive Medi-Cal

Medi-Cal A1C and Eye Exam Member Incentive Mailings						
Measure	**HEDIS Non-Compliant Members Mailed**		**Incentives Received**		**Response Rate**	
	August 2018	**June 2019**	**2018**	**2019**	**2018**	**2019**
HbA1c Test	10,891	15,196	578	510	5.31%	3.36%
Diabetic Eye Exam	15,605	5,466	629	163	4.03%	2.98%

CDC Table 8: MY2018–MY2019 HbA1c Testing and Eye Exam Member Incentive HEDIS Participation Rates

HbA1c Test Incentive Forms	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Incentive Participation Rate
2018	578	546	9,439	5.78%
2019	510	455	12,643	3.59%
Eye Exam Incentive Forms	**Forms Received**	**HEDIS Qualified**	**HEDIS Denominator**	**HEDIS Incentive Participation Rate**
2018	629	593	13,589	4.36%
2019	163	152	4,714	3.22%

C. Analysis

1. In MY2018, of the 10,891 members who were mailed the HbA1c Test incentive, 9,439 remained in the denominator. Of the 578 submitted HbA1c test incentive forms, 546 remained as HEDIS eligible, yielding a 5.78% response rate of HEDIS eligible submissions.
2. In MY2018, of the 15,605 members who were mailed the Eye Exam incentive, 13,589 remained in the HEDIS denominator. Of the 629 submitted Eye Exam incentive forms, 593 remained as HEDIS eligible, yielding a 4.36% response rate of HEDIS eligible submissions.
3. In MY2019, of the 15,196 who were mailed the HbA1c Test incentive, 12,643 remained in the denominator. Of the 510 submitted HbA1ctest incentive forms, 455 remained as HEDIS eligible, yielding a 3.59% response rate of HEDIS eligible submissions.
4. In MY2019, of the 5,466 members who were mailed the Eye Exam incentive, 4,714 remained in the denominator. Of the 163 submitted Eye Exam incentive forms, 152 remained as HEDIS eligible, yielding a 3.22% response rate of HEDIS eligible submissions.

D. Barriers

1. One of the largest barriers for the Eye Exam incentive program was the stall with VSP contracted vision providers permitting members with diabetes to get an annual diabetic eye exam. Although efforts to correct the contract has permitted diabetic members to get their exam on an annual basis — due to a delay in updating the eligibility file that was sent to VSP with a diabetes identifier — CalOptima members were turned away by VSP when in fact members were eligible for the exam.
2. HbA1c test incentive forms regularly came back with the HbA1c value field empty or it was clear members had filled out the form themselves with a blood sugar value reading instead of an HbA1c test value. In addition, a significant number of providers did not complete the retinopathy exam result on the form, often returning the forms with that field blank.
3. In MY2019, due to a data filtering error, only members missing both exams were mailed the incentives rather than members who were missing either the HbA1c test or eye exam. This error was found after the mailing was completed.
4. The target population was not identifiable until after the denominator was pulled usually in March or April of MY, thus causing a regular delay in mailing the incentives.

E. Opportunities for Improvement

1. To promote the importance of annual diabetic eye exams, regardless of whether the member falls into the HEDIS denominator or not, the diabetes incentive mailings will be mailed to all members identified with a diabetes diagnosis.
2. For greater emphasis of compliance with Diabetes HbA1c Testing and Eye Exam, along with all other incentives, there will be concerted effort for greater promotion and marketing of the diabetes member incentives through the HNs, CCN providers and in the community.

2020 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. Emerging Risk Health Coaching Telephonic Outreach

A. Description

To address emerging risk in a timely fashion, eligible members with diabetes who had an HbA1c test result below 8.0% but tested between 8.0% and 9.0% in their most recent HbA1c test were identified for telephone outreach by a health coach to identify quick solutions for returning the HbA1c levels below 8.0%.

B. Findings

CDC Table 9: 2020 Health Coaching Outreach for All Programs: MC, OC and OCC

Year	Qtr	LOB	Starting Denominator	Members assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessful Outreach	Emerging Risk Members Incomplete Assessment	No Longer Eligible
2020	Q1	OC	0	0				
2020	Q1	OCC	4	4	2	0	0	0
2020	Q1	Medi-Cal	148	143	39	5	1	0
2020	**Q1**	**Total**	**152**	**147**	**41**	**5**	**1**	**0**
2020	Q2	OC	8	0	0	0	0	0
2020	Q2	OCC	85	8	6	1	1	0
2020	Q2	Medi-Cal	731	35	22	1	12	0
2020	**Q2**	**Total**	**824**	**43**	**28**	**2**	**13**	**0**

C. Analysis

In Q1 2020, 147 emerging risk members were assigned for telephonic Health Coaching outreach with 41 successful outreach calls. In Q2 2020, 43 emerging risk members were assigned for telephonic Health Coaching outreach and had 28 successful outreach calls.

D. Barriers

Some barriers encountered during the telephonic outreach include being unable to contact the member, unable to coach the member and member opted out/declined telephonic health coaching. In addition, Health Coaches involved in this outreach discovered that the common barriers for members would be homelessness, very limited in terms of food and housing

options and limited transportation/access to care. Another barrier is that health coaches do not get all the questions answered, resulting in incomplete assessments. Health coaches were reminded to try and complete all questions to be able to close out assessments.

E. Opportunities for Improvement

1. Consider outreaching in the next year to members that declined.
2. Stagger the different call attempts at different times to see if member could be reached.
3. Connect homeless members to available homelessness services.
4. Increase awareness of available transportation services to eligible members.

Additional Targeted Diabetes Activities 2020:

- IVR campaign with HbA1c testing and statin medicine messaging for diabetics ran in July 2020 after a deliberate pause due to COVID-19 risk concerns raised by HNs.
- In August, a direct mailing of diabetic eye exam and HbA1c testing member incentives were sent to members who were still outstanding for an annual exam or test. The mailing also contained information on diabetes medication adherence and had a flier for information about the Diabetes Management Health Coaching services. The mailing was originally scheduled for May 2020, however due to the COVID-19 surges, the mailing was delayed and then adjusted to include information about taking precautions when scheduling diabetic exams or care, and for members to discuss the best care plan according to their specific needs.
- Medi-Cal and OCC member newsletter article on the importance of diabetic yearly eye exams, and statin use after a heart attack.
- Collaboration with various HNs on promoting incentive via their call campaign outreach efforts.
- Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
- Ongoing outreach calls to emerging risk population of diabetics who were well controlled, but now have an HbA1c between ≥8.0% and ≤9.0%.
- Ongoing provider fax reports of diabetic members NOT on a statin.
- Ongoing SPD quarterly mailings to educate members with diabetes NOT on a statin on the benefits of statin-use in preventing cardiovascular risk and the importance of having the discussion with their provider.
- Social media message in November 2020 emphasizing the increased for heart disease with diabetes, encouraging members to talk to their doctor about whether a statin may be right for them.

Barriers

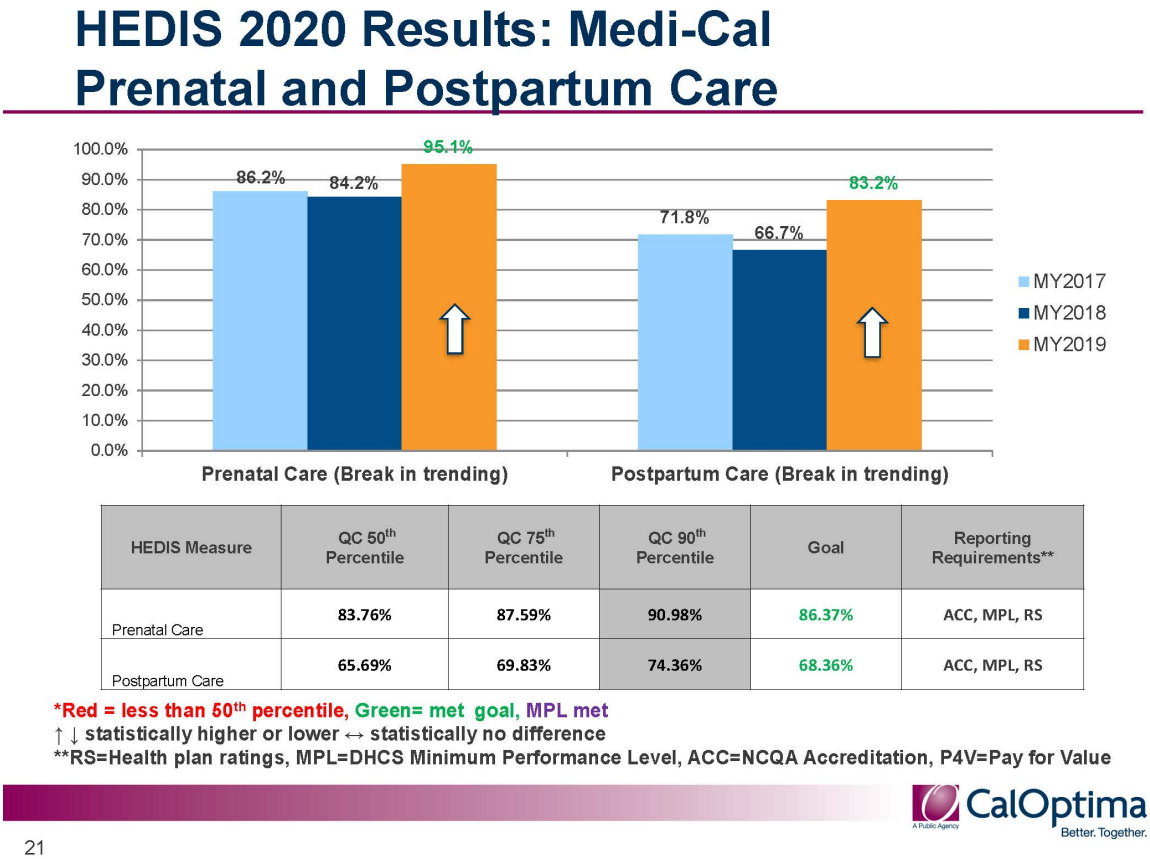
- Members confusion about their benefits related to eye exams. Members who are diabetic are covered to see a vision specialist once every 12 months, but this may not have been communicated clearly to members. CalOptima obtained approval for members to get the service every 12 months with one vendor but this was not translated into the vendor's daily operations for identifying eligible members with diabetes.
- Sharing information between specialists and PCPs sometimes does not occur, thus the PCP may not be aware of previous diabetic eye exam results or the need for an annual diabetic eye exam.
- Limitations in obtaining lab and test data from electronic health records as well as from non-contracted lab vendors.
- Reconciliation of provider data with CalOptima, as some providers use point of care and are not submitting through normal channels.
- Members are not aware of the increased risk of cardiovascular complications with diabetes.

Opportunities for Improvement

- Promote more widely the $25 member incentive program for completion of diabetic eye exams and HbA1c testing to providers through various provider communication modes such as fax blasts, provider portal, HN and provider meetings and through provider relations representatives.
- Explore Office Ally and obtaining electronic health records to improve lab data and access to diabetes medical records.
- Continue targeted call campaign and health coaching intervention for CDC identified members at risk.
- Update VSP eligibility file identification to ensure barrier is removed for annual eye exam for members with diabetes.
- Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
- Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
- Newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Prenatal and Postpartum Care (PPC)

Table 1: PPC HEDIS Rates MY 2017–2019



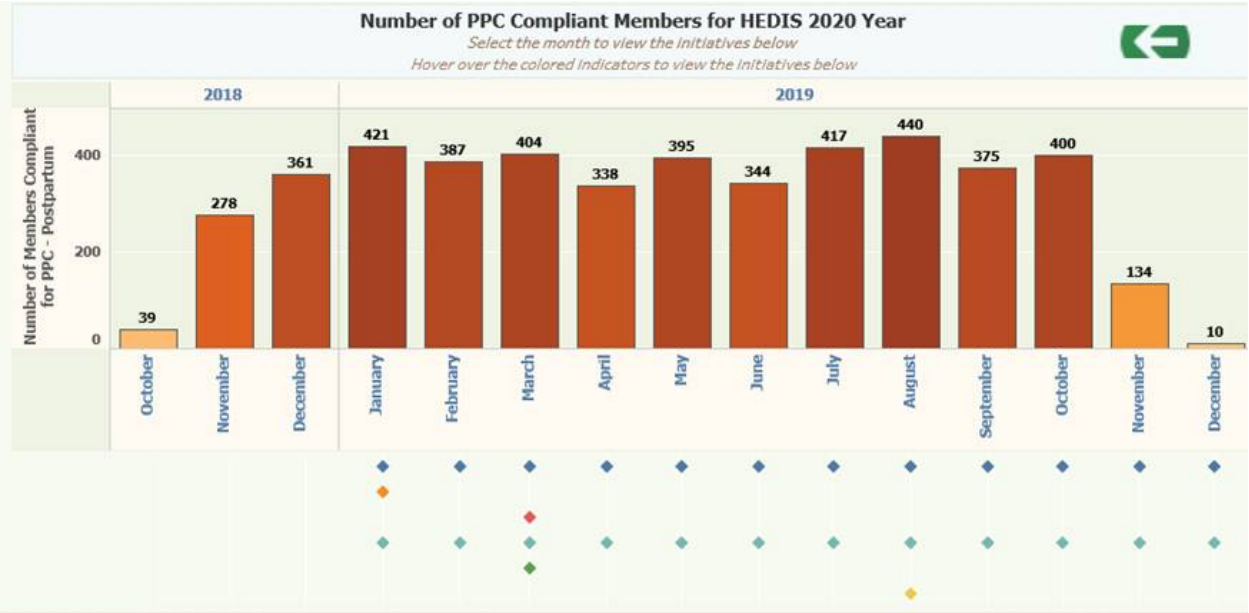
HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	83.76%	87.59%	90.98%	86.37%	ACC, MPL, RS
Postpartum Care	65.69%	69.83%	74.36%	68.36%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

The table above shows a trend analysis for Medi-Cal PPC measure for MY 2017–2019. The rates showed a significant increase from 2018–2019 from the 75th into the 90th percentile for Prenatal Care and from the 50th into the 90th percentile for Postpartum Care. However, it should be noted that this measure had a significant specification change which resulted in most plans nationally seeing a rise in their rates. (Break in trending on the graph above noted for this reason.)

Prenatal and Postpartum Care (PPC) met the 90th percentile, exceeding the MPL.

PPC Table 2: PPC Compliant Members in HEDIS 2020 MY2019



Note:PPC HEDIS 2020 (MY 2019) includes delivery of live births on or between 10/08/2018 and 10/07/2019. PPC HEDIS measure specifications changed from HEDIS 2019 to HEDIS 2020. Postpartum visit date expanded from between 21 and 56 days to between 7 and 84 days.

List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Bright Steps Program	1/1/2019	12/31/2019	2008 members	New Bright Steps program; program for moms and babies. Program includes discussing benefits of postpartum provider follow-up and incentive form during program calls.
Bright Steps Promotion at Breastfreeding Conference	1/29/2019	1/31/2019	N/A	Attended the Breastfeeding conference and tabled for Bright Steps program promotion.
Member Outreach Presentation at CBO	3/1/2019	3/31/2019	N/A	Member presentation (4 total) at Fristers, a CBO that provides service to teen and young adult moms.
Postpartum Checkup Member Incentive Program	1/1/2019	6/30/2019	24 members	$25 target gift card for completing a postpartum visit 3-8 weeks after delivery.
	7/1/2019	12/31/2019	161 members	$50 target gift card for completed postpartum visit 3-8 weeks after delivery.
Spring Medi-Cal Newsletter	3/15/2019	3/22/2019	449967* All MC members	2-page spread about Bright Steps program.
Summer/Fall Medi-Cal Newsletter	8/26/2019	8/28/2019	445214* All MC members	Bight Steps program mentioned in newsletter.

PPC Table 2 data represents all Medi-Cal members with live births between 10/08/2018 and 10/07/2019 that met the continuous enrollment criteria under the HEDIS specifications.

2019 Prenatal and Postpartum Initiatives: Medi-Cal

1. Bright Steps Program (BSP)

A. Description

The Bright Steps Program was launched in September 2018 after MOMS perinatal services ended on August 31, 2018. BSP was offered through December 31, 2018 and successfully outreached to 490 members. Not all these members were part of the HEDIS denominator. In 2019, BSP outreached to 2,008 members. This includes members who are not part of the HEDIS denominator. HEDIS Administrative Data is not reflective of full BSP Outreach efforts. Of those, 631 members in the HEDIS denominator participated in BSP. These members met HEDIS parameters related to live birth timeline and continuous enrollment.

B. Findings

PPC Table 6. BSP Participants — MY2018 and MY2019

HEDIS MY	BSP Participation **Includes Members Non-Compliant with PPC Measure**	HEDIS Denominator	BSP Participation Rate
2018	38	**6965**	<1%
2019	631	**6628**	9.52%

PPC Table 7. PPC Compliance Among Bright Steps Participants

HEDIS MY 2019			
Variables	**Total**	**Denominator (BSP Participants)**	**Rate**
BSP participants compliant with PPC HEDIS measure	473	631	473/631 (74.96%)
BSP participants not compliant with PPC HEDIS measure	158	631	158/631 (25.04%)

C. Analysis

PPC compliance was assessed among all BSP participants.

1. In MY2018, less than 1% of members eligible to participate in BSP participated, but it is not reflective of the program's impact. Low participation rates were due to the timeline of the BSP program launch after perinatal services with MOMs stopped on 8/31/2018. And 63.16% of BSP participants were compliant with the PPC HEDIS measure.
2. In MY2019, 74.96% of BSP participants were compliant with the PPC HEDIS measure. This suggests that BSP participation supports its participants in being compliant with the PPC HEDIS measure.

D. Barriers:

1. Bright Steps outreach may only engage portions of the HEDIS denominator. More widespread outreach may capture a larger portion of the eligible population.
2. BSP outreach is triggered by a pregnancy notification report, thus any failure to notify CalOptima of a pregnancy results in a missed opportunity to reach out to members and offer BSP to support their pregnancy.
3. Members may continue to be unaware of the availability of the BSP and/or the PCIP and are not taking advantage of it.
4. PCIP participation remains low among those that are compliant with the PPC HEDIS measure and complete their postpartum visit within the recommended timeframe. Members continue to be unaware of the availability of the PCIP or may be aware of it and are not taking advantage of it.
5. Comparisons between MY2018 and MY2019 PCIP participation cannot be trended due to the change in value of the health reward that went from $25 to $50.
6. PCIP needs more time to trend MY2020 results to identify its impact of PCIP on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. BSP is still in its early stages. Continue to offer BSP and find ways to augment program participation, such as increasing the accurate submission of PNRs. Continuing BSP will not only continue to provide essential services to mom and baby, but it will allow for trends to assess its impact.
2. Continue promotion efforts of BSP and PCIP among HNs, providers and community organizations.
3. Continue to offer PCIP to BSP participants. It is too soon to trend its impact on PPC HEDIS measure compliance. However, the incentive may also bring about other benefits to mom and their newborn such as financial support during a time that is typically characterized by multiple expenditures.

2. Postpartum Checkup Member Incentive MY2018–2019 6/22/2018–11/2/2018

A. Description

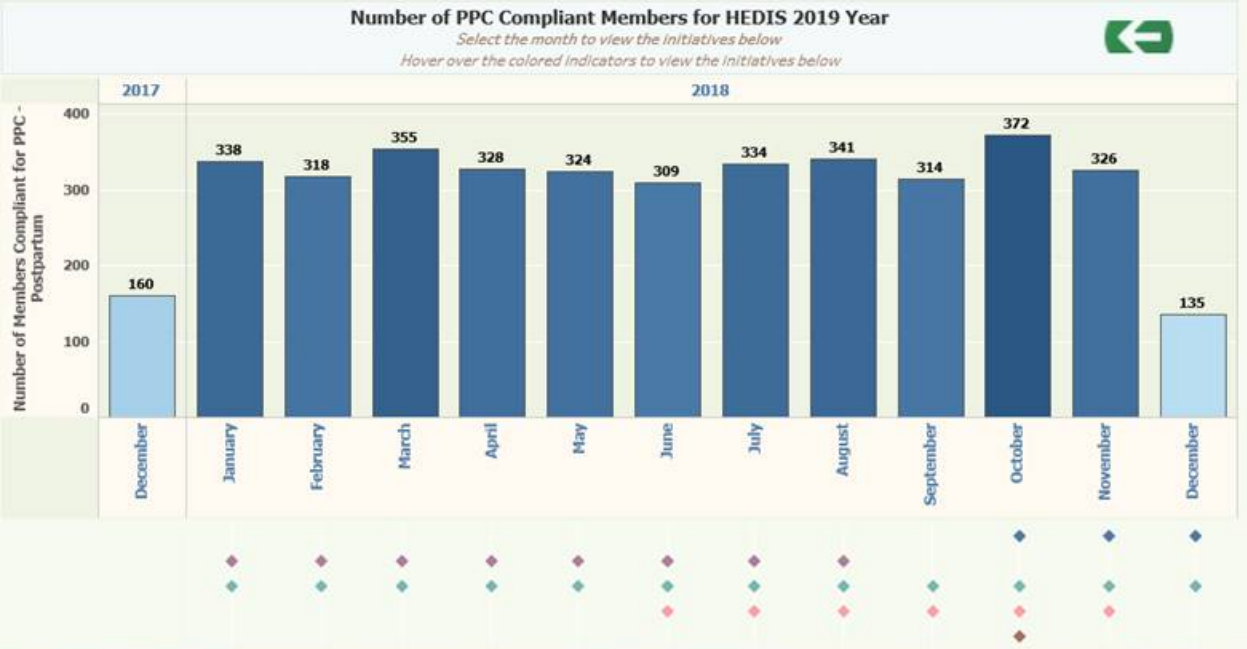
In MY2018, 1,010 eligible pregnant members were identified and mailed postpartum packets containing the PPC member incentive which encouraged members to complete their postpartum visit. These mailings occurred from 6/22/2018 through 11/2/2018. In an internal transition of responsibilities, these postpartum packets were replaced with BSP packets and were made available to members upon request. Mailings of packets were intermittent after November 2018 while the BSP was being resourced and staffed. Processes became more standardized by Q1 2019. In MY2019, 2,008 members were outreached to offer BSP and participating members were mailed BSP packets that contained the postpartum check member incentive.

B. Findings

PPC Table 3. Postpartum Checkup Incentive Submissions MY2018 and MY2019
The tables below show the participation rates and impact on the PPC HEDIS measure across MY2018–2019.

HEDIS MY	PPC Incentive Submissions	PPC Measure Denominator (Total births)	Response Rate
2018	71	6965	**(71/ 6965) 1.02%**
2019	115	6628	**(115/6628) 1.74%**

PPC Table 4: PPC Compliant Members in HEDIS 2019 MY2018



Note: PPC HEDIS 2019 (MY 2018) includes delivery of live births on or between 11/06/2017 and 11/05/2018. Postpartum visit date can occur anytime between 21 and 56 days after delivery.

List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Bright Steps Program	10/1/2018	12/31/2018	490 members	Launch of new Bright Steps program.
MOMS Perinatal Services	Started before 2017	8/31/2018	N/A	MOMs is contracted to provide perinatal services to our Medi-Cal members.
Postpartum Checkup Member Incentive Program	1/1/2018	12/31/2018	82 members	$25 target gift card for completing a postpartum visit 3-8 weeks after delivery.
Postpartum Packet Mailing	6/22/2018	11/2/2018	1010 members	Mailed PPC incentive flier with MEM7 Postpartum Packets
Provider Communication Promoting Bright Steps	10/25/2018	10/25/2018	62 CPSP Providers; 434 Non CPSP Providers	Fax blast to OB providers regarding the launch of Bright Steps, pregnancy notification reports and requirements for CPSP providers.

PPC Table 5. PPC Incentive Submissions by Compliant Members MY2018 and MY2019

HEDIS MY	Members in Compliance with PPC Measure that Participated in PPC Incentive	Total Members in Compliance with PPC Measure	PPC Incentives Submitted By Members Compliant with PPC Measure
2018	56	3954	**(56/3954) 1.41%**
2019	102	4743	**(102/4743) 2.15%**

C. Analysis

1. In MY2019, 71.56% of members were complaint with the PPC measure and received a postpartum visit between 7 and 84 days after delivery. This represents a 14.79% increase in compliance from MY2018. The increase in PPC measure compliance rate is likely due to the expansion of the postpartum measure visit date from between 21 and 56 days in MY2018 to between 7 and 84 days in MY2019.
2. MY2018 PCIP participation rates were low and did not seem to support an increase in PCC measure compliance. While there is an increase in the postpartum checkup incentive program (PCIP) participation in 2019, especially after the health reward value increased

from $25 to $50 in July 2019, there is no suggestion that the increased value of the health reward was the sole reason behind the increased PPC HEDIS measure compliance.

D. Barriers

1. A one-time mailing is not sufficient to alert members of the key importance of postpartum checkup. Low participation rate could be attributed to lack of incentive awareness.
2. In 2019, the date ranges on the incentive form remained at getting a postpartum check at 3–8 weeks postpartum. The form was not updated until February 2020 with the updated date range of 1–12 weeks postpartum.

E. Opportunities for Improvement

1. Continue to promote Bright Steps Program and brand recognition as well as adding of staff.
2. Utilize PPC incentive in a more comprehensive effort to target new mothers to go in for their postpartum check.
3. Continue to incorporate postpartum checkup incentive forms into all Bright Steps maternal packets
4. Implement standard work for trained Bright Steps personal care coordinators to inform members and help schedule postpartum check exams and to take advantage of the incentive offer.
5. Implement a more robust promotion strategy of PPC measure through publicizing the incentive program linked with the Bright Steps program and PPC member incentive to ensure members are aware of the importance of their postpartum checkup.

Additional PPC Activities in 2019

- Tabled and promoted BSP at Breastfeeding Conference in March 2019.
- Presented BSP at Fristers, a community-based organization that provides services to teen and young adult moms.
- PPC incentive program for $25 gift card to Medi-Cal members who complete their postpartum checkup between 3–8 weeks after delivery. It had 24 members that participated in the incentive program.
- PCC incentive program revised in July 2019, increased gift card to $50 to Medi-Cal members who complete their postpartum checkup between 3–8 weeks after delivery. It had 160 members participated in incentive program.
- BSP was able to outreach to 2,008 members providing health education, discussing benefits of postpartum provider follow-up and incentive form during program calls.
- Published two-page spread about BSP in Spring 2019 Medi-Cal newsletter discussing the importance of postpartum care.
- Included BSP promotion in Summer 2019 Medi-Cal newsletter.

2020 Prenatal and Postpartum Initiatives: Medi-Cal

- From January 1, 2020–October 15, 2020, the BSP PCCs made 3,061 attempted outreach calls based on PNRs, self-referrals, HN referrals and internal referrals. Of which, 1,792 initial or postpartum assessments were completed for initial or postpartum (PP) assessments which included a BSP packet sent that included a PPC incentive form.
- All members were outreached to and provided verbal education throughout pregnancy/postpartum and/or provided mailed health education materials that included the postpartum incentive form. Of which, 1,100 postpartum members were called to complete a PP assessment and reminded of the PP visit, over 600 completed the calls and received a PP follow-up reminder verbally by BSP staff.

- The PPC incentive form was updated to represent the longer range between 7 and 84 days postpartum, that the checkup allowed.
- Collaborated with engaged HNs with their call campaign outreach efforts and exchanged data.
- Comprehensive Perinatal Services Program, and an overview of CalOptima's BSP. Also, sent obstetrics providers prenatal/postpartum materials and a BSP prenatal and postpartum care poster.
- Provide HCA Women, Infants, and Children (WIC) sites with BSP prenatal and postpartum care poster to hang in WIC waiting rooms.
- Uploaded the PPC incentive form to CalOptima website for increased member access.

Barriers:
- COVID-19 has become a barrier for prenatal and postpartum care among members.
- A significant number of members that have delivered via c-section have been going in for the wound check visit within the first two weeks and not returning for a postpartum visit between days 21–84 days of delivery.
- Lack of mental health and substance use support in Orange County for pregnant and new moms, which ultimately reduces these members attending prenatal and postpartum visits.
- Providers notifying CalOptima of pregnancies through PNRs. Reduced PNRs results in a missed opportunity to support a member's pregnancy through participation in BSP.
- Teen moms have a barrier in obtaining vaccines during pregnancy because they must get them at their PCP and not their OB. Adding an additional visit, may deter members.

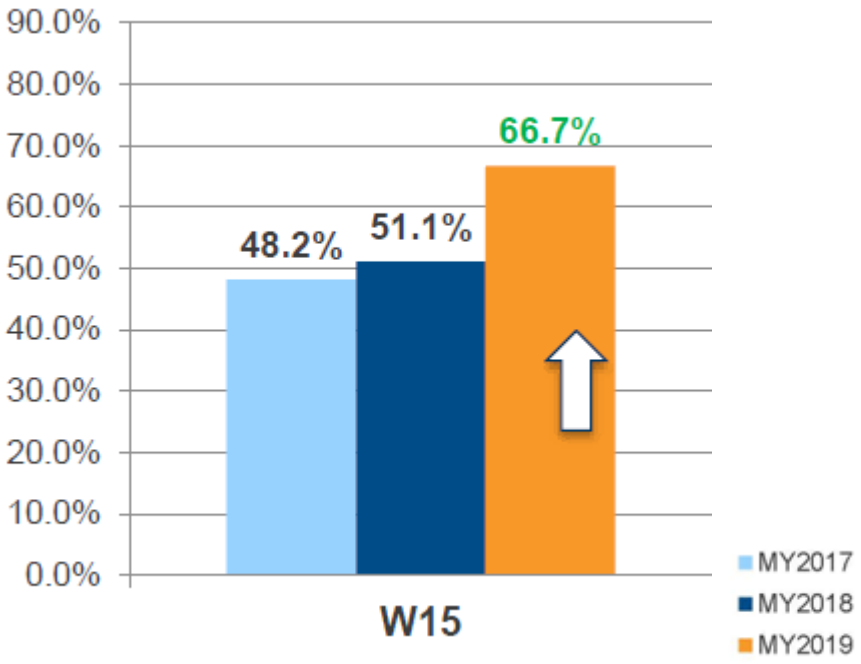
Opportunities for Improvement
- Coordinate promotional campaign to members, providers and community partners for BSP emphasizing the $50 PPC member incentive program.
- Promote CalOptima website and social media platforms with an educational message about women's health and maternal mental health awareness messaging in May 2020.
- Improve collaboration with HNs and CCN providers to promote prenatal and postpartum visits.
- Create a BSP booklet with pregnancy, postpartum and infant information. The booklet will tie in CalOptima benefits and programs.
- Incorporate Adverse Childhood Experiences (ACEs) screening and trauma informed care approach prenatal and postpartum care.

Well-Child Visits in the First 15 Months (W15)

The W15 measure became the top priority initiative in 2019 and 2020, focusing on increasing compliance rates for the W15 measure, which requires the completion of six well-child visits for members from birth to before their 15-month birthday. CalOptima has consistently scored in or below the 50th percentile in 2017 and 2018 and was at risk of not meeting MPL for MCAS requirements which would then lead to potential sanctions and a corrective action plan.

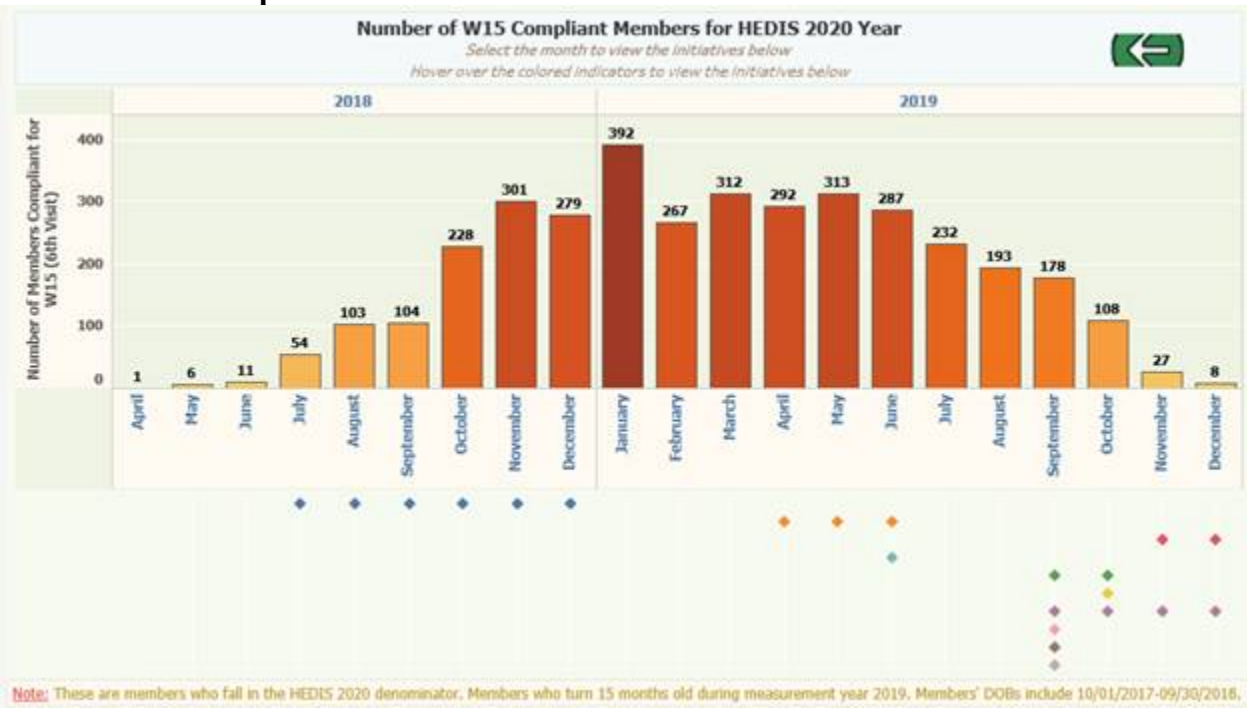
Performance Against Goal:
The table below shows a trend analysis for Medi-Cal W15 rates for MY2017–2019. The rates were consistently below the 50th percentile for two years, however, rates shot above the 50th percentile in MY2019. The W15 measure met the 50th percentile MPL and met goal of 65.83% in MY2019.

W15 Table 1: Number of W15 Compliant Members for HEDIS 2020 Year



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15)	65.83%	69.83%	73.24%	65.83%	MPL, P4V

W15 Table 2: Compliant Members for HEDIS 2020 Year



W15 Table 2 represents all new compliant (six or more visits by 15 months) members by month between April 2018 and December 2019 (n=3696). These members fall in the HEDIS 2020 W15 denominator (N=7765). W15 HEDIS administrative rate is 47.60%. Note, W15 measures members who turn 15 months in the measurement year, however, members age out at different times

throughout 2019. W15 initiatives began in full force in Quarter 3 and 4 of 2019. There was a spike in members identified as completing six well-child visits in January 2019, n=392.

2019 Well-Child Visit in the First 15 Months Initiatives: Medi-Cal

1. CalOptima Day Phase 1 04/17/2019–06/26/2019

A. Description

To address the consistently low performing W15 measure, a concerted campaign to increase the number of W15 visits within compliant timeframe began in April 2019. High volume offices with members who were non-compliant were provided outreach lists to schedule members for CalOptima Day events focused mainly towards W15 and other pediatric well care visits. Members who attended received a $25 gift card and promotional items. Providers received a check of up to $2,400, depending on their tier.

B. Findings

1. There were 11 HNs/provider offices that participated, which yielded 18 child and adolescent events.
2. There were 876 children who participated in CalOptima Days, with 870 were CalOptima Medi-Cal members.
3. Out of 40 of the 870 CalOptima Medi-Cal members who participated in CalOptima Day Phase 1, fell into the MY2019 W15 HEDIS denominator.
4. Attending CalOptima Day event helped impact 22 member's HEDIS numerator count (e.g. visit counted towards Visit 3, Visit 4, Visit 5).
    - With 7 members that became compliant on the CalOptima Day event.
5. Of which, 22 of these 40 members are compliant for W15 by end of measurement year.

C. Analysis

1. Assumptions: Membership (denominators) for clinics are fluid throughout the measurement year due to members losing eligibility, regaining eligibility—e.g. HEDIS technical specifications has an allowable enrollment gap of 45 days, or being completely terminated.
2. Unable to correlate if attending a CalOptima Day is the reason why a member became compliant for W15 since it requires a series of well-care visits but can assume it contributed to a visit numerator hit.
3. Based on claims and encounters received through August 2019, 35 W15 members had a DOS on CalOptima Event Date. Of those, the data showed the member's visit complied with W15 and/or CIS measure. Even though the events did not outreach to many W15 members, the ones who did come in impacted the following measures:
    - CIS only: 1 member
    - CIS + W15: 10 members
    - W15 only: 24 members

D. Barriers

1. Scheduling challenges and inconsistencies in information relayed to members for CalOptima Day resulted in member confusion and delay of gift card assignment.
2. Provider offices had limited resources to call the members on the outreach lists, which required offices to reconcile with their internal records for most updated contact information, eligibility, and measure compliance.
3. Exchange of outreach lists and schedules were difficult as some offices did not have an established secure email portal or could not get access to Cisco.

4. Reminder letters required a lot of administrative work and had to be completed in a short timeframe. Letters did not seem to generate a high yield of responses.
5. CalOptima's data is not up to date with claims lag.

E. Opportunities for Improvement

1. Stop offering to send outreach lists to participating PCP offices in the future since CalOptima's data is not up to date with claims lag.
2. Do not send reminder letters to members who are scheduled for CalOptima Days as it is resource intensive with low yield. Provider offices tend to have their own method of appointment reminder (e.g. text or phone call day prior).
3. Establish roles and responsibilities in the planning stages of CalOptima Day to understand who can be contacted for deliverables and who will be available on-site on event day.
4. Focus on a targeted HEDIS measure with a smaller population to increase probability of increase HEDIS rate.
5. Do not provide or promote promotional items.
6. Do not require CalOptima to table the event or sign out gift cards. Remove member incentive all together to eliminate administrative accountability.
7. Discuss with participating offices appropriate coding and best billing practices. Incorporate a requirement for immediate claim and encounter submission as part of the provider incentive.

2. W15-Only CalOptima Days 11/19/2019–12/19/2019

A. Description

In an effort to refocus on scheduling only W15 visits and move away from other pediatric or piloted adult well care visits, 4 clinic sites participated in W15-only CalOptima Days in Q4 2019. A total of seven CalOptima Day events occurred, as each site could host more than one event in the same week.

- Strong Kids Medical Group
- Pediatrics & Neonatology
- South Coast Pediatrics
- Friends of Family Health Center

1. Provider offices outreached to any members ages 0–15 months old. Patients had to be a CalOptima Medi-Cal member.
2. Unlike previous CalOptima Days, outreach lists were not provided to the office.
3. Event day schedule lists and final HEDIS 2020 Rates used to evaluate.
4. Provider offices received an incentive for hosting CalOptima Day.
5. No member incentive was provided for this series of CalOptima Days.

B. Findings

1. Only 24 of the 129 members who participated in the W15-Only CalOptima Day fell into the MY2019 W15 HEDIS denominator.
2. Attending W15-only CalOptima Day event helped impact two member's HEDIS numerator count.
3. One member became compliant on the CalOptima Day event.
4. Of which, 11 of these 24 members were compliant for W15 by end of MY.

W15 Table 3: W15 CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed HEDIS Eligible Members
South Coast Pediatrics	66	52	78.79%	44
South Coast Pediatrics	4	3	75.00%	2
South Coast Pediatrics	16	15	93.75%	15
Pediatrics and Neonatology	47	34	72.34%	34
Strong Families Santa Ana	21	14	66.67%	14
Friends of Family (Tustin)	6	4	66.67%	1
Friends of Family (LH)	63	31	49.21%	19

C. Analysis

1. Offices were able to outreach and identify their 0–15 months population without needing CalOptima's administrative help.
2. Average attendance rate was 71.77% which was higher than the CalOptima Days Event in Q2 2019 (67.17%).
3. Final HEDIS 2020 W15 Admin Rate was 47.60% (excluding Kaiser members).
4. Impact to administrative rate: 0.013% (1/7765). Overall, the CalOptima Day Events did not impact the HEDIS population as desired, as a small percentage of those who attended impacted the administrative rate.

D. Barriers

1. In an effort to ease the scheduling process, the offices were able to outreach to *any* Medi-Cal member that falls into the 0–15 months age range, therefore member visits may not have been included toward the W15 HEDIS 2020 rate due to specific eligibility requirements.
2. The CalOptima Day events in Q4 2019 were a year-end effort to improve W15 rate, so all six visits may not have been able to be scheduled and completed before the end of the calendar year.
3. There's inaccuracy in relying on the offices to know which visit in the series of six the member was coming in for.
4. Offices schedule members for the well-child visits at different age increments, not necessarily in compliance to the 6 visits *before* 15 months that HEDIS specifications stipulate.
5. It was difficult to conclude that CalOptima Days made a significant impact on the overall increase in W15 rates versus other simultaneous intervention efforts, including supplemental encounter and data capture, educational campaigns and the member and provider W15 incentives.
6. Total of $8,000 in provider incentives was spent on these CalOptima Days. The return on investment (ROI) was low; the impact on W15 HEDIS rate was 0.013%.
7. CalOptima Days were a good avenue to engage and educate the provider offices on the effort to improve well-child visit rates. The coordination provided an avenue to correct

certain provider office well-child schedules and to provide an exchange of data and a closer look at their data.

8. Future proactive provider engagement regarding data should be pursued considering W15 is a P4V measure and there seemed to be confusion on measure expectations.

E. Opportunities for Improvement

1. Discontinue CalOptima Days due to the significant amount of staff time and resources required to coordinate, execute and follow up with member and provider incentive payouts

3. Health Guide 0–2 Newsletter 06/21/2019

A. Description

Health Guide 0–2 newsletter mail dropped on 06/21/2019 and targeted 10,991 Medi-Cal members ages 0–2 years old and fell into the CIS and W15 denominator, using March 2019 prospective rate (PR) data to filter mailing list. For the evaluation please see the HEDIS 2020 Final Rates.

B. Findings

1. The Health Guide 0–2 newsletter was mailed to 6510 members in the W15 HEDIS denominator .
2. After receiving the mailing, 830 of the 6510 members completed their 6th well-child.
3. By end of MY, 2,848 of the 6510 members were complaint for W15.
4. Participation by 160 of the 6510 members in the W15 4-6 incentive program. Of which 132 of the 160 members were compliant for W15.

C. Analysis

1. Even though 830 members completed their sixth well-child visit and became complaint ***after*** receiving the Health Guide 0–2 mailing, we cannot correlate the mailing as the reason they visited their provider. Members may have had other outreaches/touchpoints. The Health Guide 0–2 mailing occurred midyear in June, before the incentive was launched in September.
2. The newsletter mailing project (including postage) cost $13,714.43. If the mailing was the reason members visited their providers, the cost was approximately $16.52 ($13,714.43/830) per member for each HEDIS hit.

D. Barriers:

1. Health Guide 0–2 newsletter only included member health education regarding well-child visits and vaccinations. No well-child visit incentive form was included.
2. No direct correlation between receipt of the health guide and the child's visit to the provider.

E. Opportunities for Improvement

1. Make the Health Guide available online and promote the newsletter through other avenues (e.g. Community Connections).
2. Use Health Guides as supplemental education source if members need it.
3. Stop Health Guide mailing.

4. Well-Child Visits 4–6 Member Incentive 09/01/2019–12/31/2019, and Targeted Mailing 09/03/2019

A. Description

Medi-Cal CalOptima members ages 0–15 months are eligible for Well-Child Visits 4–6 incentive if they complete six well-child visits before turning 15 months old. The form must be completed by their provider and faxed in within 60 days of the sixth DOS. The incentive program launched 9/1/2019 and ran through 12/31/2019. An updated incentive form launched 1/1/2020. A targeted mailing was dropped on 09/03/2020 as a concerted effort to reach out to members who were due for W15. Mailing quantity: 1627, based on June provider relations data. The following evaluation is data is from PHM Incentives Database and final HEDIS 2020 rates.

B. Findings

1. The incentive mailing was sent to 1299 W15 members in the denominator.
2. Of which, 821 of these 1299 W15 members were compliant for W15 by end of measurement year.
3. Total incentive forms received: 276
4. Total qualifying for HEDIS (fell in the W15 denominator): 176
5. Actual members compliant for HEDIS: 145

C. Analysis

1. In 2019, of 276 W15 incentive forms received, 176 members were in the W15 measure denominator. The incentive participation rate for the HEDIS 2020 W15 measures was 10.82% (176/1627). Of the 176 submitted forms there were 47 forms (26.74%) had a sixth visit DOS that matched our claims/encounters data that fit all Quality Spectrum Insight (QSI) HEDIS criteria.
2. Of the 1627 members that were targeted, 1299 were in the denominator for the HEDIS 2020 W15 measure. Of those who were mailed the incentive, 666 completed their sixth well-child visit after the mailing.
3. Targeted mailing is not an effective way of getting members to come in for their well-child visits. Only 97 of the 666 members who were W15 compliant and received the outreach mailing, completed their sixth visit and received the incentive. Only 14.56% of members took advantage of the incentive program.

D. Barriers

1. W15 age group is 0–15 months old, however only those turning 15 months old in the measurement year technically falls into the HEDIS measure. So those who are too young, may have completed six visits but are not counted toward W15 denominator until the year after.
2. Since the submissions are not bumped up against claims and encounters, the sixth DOS is not validated. Incentive form was taken at face value.
3. Anecdotal qualitative data showed that in clarification inquiries with various provider offices, certain members were unable to complete their sixth W15 visit before their 15 month birthday, because providers were routinely scheduling members after the member turned 15 months.
4. Unable to correlate if the targeted mailing is the reason member completed the well-child visit series.

E. Opportunities for Improvement

1. This incentive was a pilot program. Will continue as planned and launch Well-Child Visits 1–3 and Well-Child Visits 4–6 incentives.
2. Will bump up submissions against claims and encounters data for 2020 submissions for provider payment. There will be leniency for the member since the provider is attesting to the form.
3. Provide clearer instructions of the measure requirements of when the sixth visit is to be completed.
4. Do not do targeted mailings in the future, rather disseminate incentive program through PCPs.

5. Well-Child Visits 4–6 Provider Incentive Program 09/01/2019–12/31/2019

A. Description

Provider outreach was conducted via fax blast (273 providers), twice. Information was disseminated to HNs through email communications and various network relations meetings and monthly quality meetings. If incentive form was submitted timely and met all incentive criteria, then provider incentive was approved. Did not validate submission (sixth DOS) against claims and encounters data.

B. Findings

1. 49 unique providers participated in the W15 4–6 inventive program pilot
2. Q4 2019 breakdown:
   - Total submissions: 306
   - Total approved: 191
   - Total denied: 115
   - Total incentive: $9,550

W15 Table 4. Well-Child Visits 4–6 Provider Incentive Summary

Incentive Program	Total Submissions	Total Approved	Total Denied	Total Incentive
W15 4–6 Provider	**306**	**191**	**115**	**$9,550**

C. Analysis

1. Approved 191 submissions for provider incentive. However, only 176 members who participated in the incentive program fell into the W15 denominator.
2. An incentive sent to 49 providers for participating in the Well-Child 4–6 Visits provider incentive program. Total payout for Q4 2019 was $9,550. *Note: a few Q1 2020 was accidentally processed along with this batch.*

D. Barriers

1. Incentive forms were taken at face value and DOS were not validated against claims and encounters data.
2. It is probable that more sixth DOS are accurate and claims and encounters were received, but member or visit did not meet all W15 HEDIS specifications to be a numerator hit in QSI.

E. Opportunities for Improvement

1. Revise W15 4–6 incentive form and promote the incentive parameters clearer.

2. Try to touch base with provider offices as incentives are received and processed so there can be education real time to prevent same mistakes moving forward.
3. Bump up submissions against claims and encounters data to validate DOS. Even though incentive parameters were strictly enforced for providers, per the Final HEDIS 2020 rates we learned that most of the incentives submitted were not accurate despite promoting the incentive form as an "attestation."

6. Well-Child W15 Call Campaign 09/13/2019–10/04/2019

A. Description

The W15 call campaign was conducted between 09/13/2019–10/04/2019 targeting members who have an opportunity to complete six well-child visits before turning 15 months old and to promote the Well-Child 4–6 Visits member incentive based on June W15 2019 provider relations data.

B. Findings

1. There were 574 of the 724 members outreached for the Well-Child Call Campaign that fell in the W15 denominator.
2. Of which 471 of the 574 members in the HEDIS denominator were successfully outreached, meaning there was a live phone call with the member or a complete voicemail left regarding well-child visits.

W15 Table 5. Well-Child Call Campaign Summary

	Successful W15 Call	Unsuccessful W15 Call	Total Calls	Rate of Successful Calls
Call Campaign Members Identified	**568**	**156**	**724**	**78.45%**
HEDIS 2020 W15 Denominator	**471**	**103**	**574**	**82.06%**

C. Analysis

1. Had 150 members who were a part of the W15 call campaign fall out of the W15 denominator or was a Kaiser member.
2. Calls to 65.06% (471/724) was successfully outreached to a W15 member.
3. With 361 of the 471 members were compliant for W15 by end of MY.
4. Of which 59 of the 471 members completed their sixth well-child visit after receiving the telephonic outreach. Impact to W15 HEDIS rate was 0.76%. Note, we assume the 59 members completed their sixth visit due to the outreach call.
5. And 12 members who were successfully outreached telephonically, completed their sixth well-child visit after outreach call and submitted an incentive form.

D. Barriers

1. The outreach list was limited to members who were identified as being able to complete six well-child visits, which meets CalOptima's goal of improving our W15 rate.
2. Anecdote from member's parents or guardian:
   - Did not receive the targeted mailing; had to re-mail incentive form.
   - Was not aware they needed to complete six well-child visits before 15th month birthday.
   - Did not know which visits the child had completed.

E. Opportunities for Improvement

1. Recommend a targeted call campaign again in the future to help increase HEDIS rate.
2. Conduct the calls more periodically throughout the year verses one time at the end of the year will minimize members left — who have not aged out — to impact the rate.
3. Prepare a targeted outreach list as a standard work to sustain high successful call rate 82.06%.

7. W15 Root Cause Analysis Survey Incentive 10/10/2019–10/31/2019

A. Methodology/Data

In an effort to identify reasons why the first and second visits were difficult to find data for, an internal Initial Health Assessment (IHA) Core Report was utilized to identify members with a Date of Birth = June 2019 who showed as having completed an initial health visit. The rationale was to identify members who likely did go in for a W15 first or second visit within the first three months of life, but which had not been submitted as a claim or as a well-child-visit encounter administratively. Health educators were provided a survey and script which asked parents where they took their newborns for their first well-child visit post-delivery. The member was offered a $15 gift card for participating in the telephonic survey.

B. Findings

1. Call attempts were made to 94 members.
2. Parent or guardian may have provided more than one well-child visit in the first three months of life.
3. Data is based on QSI prospective rates, well-child visits claims/encounters received and processed as of November 2019.
4. Of which 22 of the 31 members surveyed had a well-child visit claims/encounters in the first there months of life.

C. Analysis

1. There was 70.97% (22/31) of members that had a well-child visit in the first three months of life.
2. There had been 22 newborns with at least one well-child visit in the first three months of life.
   - 29.63% had a well-child visit between birth–2 weeks old
   - 7.41% had a well-child visit at 1 month old
   - 33.33% had a well-child visit at 2 months old
   - 14.81% had a well-child visit at 3 months old

D. Barriers

- Parents did not know the exact date or provider name who completed the well-child visit.
- Parents needed education to differentiate between a sick visit and well-child visit.
- CalOptima does not have data on these well-child visits, even though the calls were made when a child was three months old. There is a data gap.

E. Opportunities for Improvement

- Work with HEDIS team to map out logic to better identify well-child visits administratively.

Additional W15 Activities in 2019

- 2019 Medi-Cal newsletter highlighted the *Don't Forget to Vaccinate, Get Shots at No Cost* article discussing the importance of well-care visits, immunization requirements for kindergarten and information on measles.

2020 Well-Child Visits Before 15 Months Initiatives: Medi-Cal

1. CHOC Health Alliance (CHA) CalOptima Day 03/04/2020–03/05/2020

A. Methodology/Data

CalOptima Day was planned for Q4 2019 with the other W15 only events, however the event was moved to March 2020. CHOC Health Alliance dedicated two sites for CalOptima Day and focused on members who are due for W15, W34, or AWC.

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments scheduled, 103 attended and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments scheduled, 64 attended and 45 confirmed CalOptima Medi-Cal members.

W15 Table 6. CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed CalOptima Medi-Cal Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. Total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance had a high attendance rate 78.05%–90.35%

D. Barriers

1. Difficulty communicating with CHOC Health Alliance. Had to go through a mediator to get the event going.
2. There was a change in staff which led to delays.
3. Office manager requested to include more members because they were unable to schedule W15 only members. Decision to allow CHA to open their schedule for W15, W34 and AWC members.
4. Post event it was difficult to get the schedule list from the sites to confirm the visits.
5. It was helpful to remove administrative burden on CalOptima to provide outreach lists and send reminder letters. However, without the proper champions on-site it made it difficult.

E. Opportunities for Improvement

1. Discontinue CalOptima Days for the W15 initiative.
2. Encourage designation of a proper champions on-site to continue member outreach.

2. Well-Child Visits 1–3 and 4–6 Member and Provider Incentive 01/01/2020–current

A. Description: Continue the first full year of W15 incentives.

1. Well-Child Visits 1–3: CalOptima Medi-Cal members ages 0–6 months old who complete at least three well-child visits by six months of age qualify for $50 gift card incentive.
2. Well-Child Visits 4-6: CalOptima Medi-Cal members ages 0-15 months old who complete at least six well-child visits before 15 months of age qualify for $50 gift card incentive.
3. Provider was incentivized $50 incentive for every eligible member submission. Well-Child Visit DOS for third and sixth visit will be validated through claims and encounters data.

B. Findings

1. PHM Incentive Database, as of 10/7/20:
   - Well-Child Visits 1–3
     - 1,073 records have been processed
       - 970 records have been approved = $48,500
       - 91 records have been denied
       - 12 records are pending
   - Well-Child Visits 4–6
     - 532 records have been processed
       - 480 records have been approved = $24,000
       - 42 records have been denied
       - 10 records are pending

W15 Table 7. Well-Child Incentive Program Response Rates as on 10/07/20

Incentive Program	HEDIS MY2020 W15 Population	Number of Submissions	Response Rate
W15 1-3	8752	1073	12.26%
W15 4-6	8752	533	6.09%

C. Barriers and Analysis

1. There are more W15 1–3 visit completed submissions than the W15 4–6 visit submissions. The way the incentives were split contributes to a failure to emphasize the need for six visits before 15 months. While the purpose of splitting the W15 incentive in to two parts was to motivate parents at the mid-point to complete W15 4–6 that is not what the preliminary results show. The way the incentives are split, there is no way to determine which visits in the series the dates of service point to. W15 1–3 incentive has approximately 50.33% more submissions than W15 4–6 incentive. The completion of six visits before 15 months is difficult to do due to the lack of continuity with one provider, or non-HEDIS compliant schedule being applied to schedule visits. There is an obvious continued drop off of the fifth and sixth visits.

2. Prospective rates show the rates for W15 1–4 visits are doing better in MY2020 over last year. Visits five and six are behind 9% but are starting to trend in a positive direction. However, a separate evaluation is yet to be completed to see how greater supplemental data and encounters may be the greatest factor, in higher rates.
3. It appears that provider offices are not using the incentive to drive historical non-utilizers to come in for visits, but rather providers are utilizing the incentives to reinforce completed utilization and capitalize on the extra income source for both themselves and members during this unique 2020 year.
4. While most providers seem to follow the Bright Steps well-child visit guidance, discussions with several offices provide evidence that some providers skip the one month old and nine-month-old follow up visit because there is no vaccination required. Offices tend to align their well-child visits with the vaccination schedule. The incentive program has created opportunity to educate participating provider offices on HEDIS expectations and how modifications can be made to well-child visit scheduling to meet measurement standards.
5. Provider office must submit claims and encounters for visit in order for this incentive to be measurable and effective.
6. The W15 incentive in its current format has limitations due to good provider involvement and positive member experience in light of COVID-19. The W15 incentive will continue until a new well care general incentive is discussed and developed to promote overall well care visits especially as the W15 measure is being combined into a Well-Child Visits in the First 30 Months (W30) combined measure, extending the age range from 0–30 months.

D. Opportunities for Improvement

1. Sunset the W15 member and provider incentives at the end of 2020 calendar year due to fiscal constraints and depletion of budgeted funds.
2. Preliminary evaluation shows that most member incentives submitted only reflected three visits, and a smaller portion of submissions were for all six visits completed before the 15 month birthday. This suggests that the incentives are not used to motivate utilization as intentioned.
3. The W15 measure is being combined into a Well-Child Visits in the First 30 Months (W30) combined measure, extending the age range from 0–30 months.
4. Notify HNs and providers that the W15 incentive is ending at the end of 2020 calendar year.

Additional W15 Activities in 2020

- **Health Guide 0–2 newsletter and W15 incentive mailing** dropped 07/24/2020 to 8,960 members ages 0–12 months old in English, Spanish and Vietnamese. Members 0–6 months old received W15 1–3 and W15 4–6 incentive form = 3,894. Members 7–12 months old received W15 4–6 incentive form = 5,066
- ***Well-Child Visits During COVID-19 Pandemic*** article in the May Provider Update discussed the importance of continuing well-child visits during the pandemic in accordance with AAP guidelines. Care for newborns and well visit and immunizations of infants and young children (through 24 months of age) were prioritized.
- ***2020 CalOptima Member and Provider Incentive Programs*** article in the July Provider Update. Article discussed CalOptima's PHM incentive opportunities, clarified incentive eligibility requirements, and reiterated the W15 member and provider incentive criteria.
- ***Well-Care Visits and Vaccinations During a Pandemic*** in the Orange County Immunization Coalition (OCIC) Summer newsletter.

- **Post Bright Steps Well Baby Follow-Up Call Project in September 2020.** After a mother graduated from the BSP by completing the Postpartum Assessment, the Bright Steps team created an activity to follow-up with the baby in either two weeks or when baby was three months old depending on their risk level. In the first month, 82 members were identified in the queue for telephone outreach for W15 well-child visits and vaccinations.

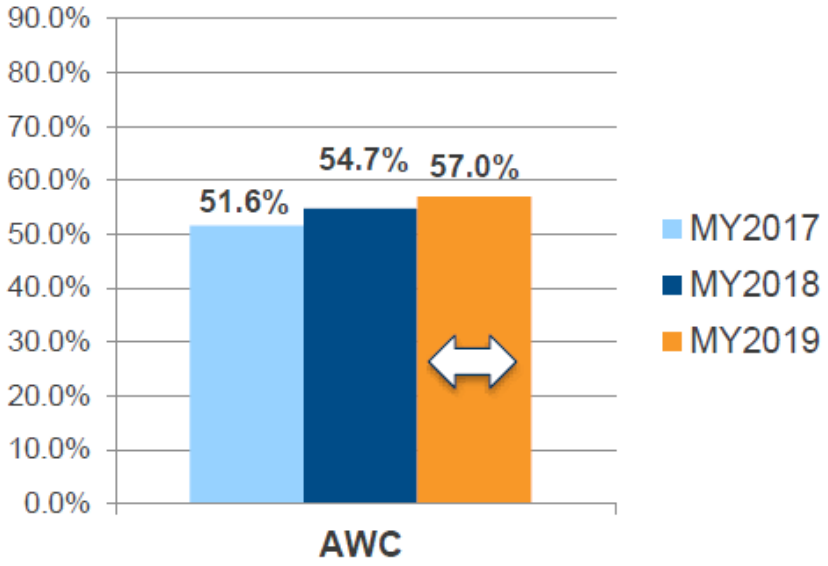
Opportunities for Improvement:

- Conduct a formal evaluation of how data gaps can be closed, since the W15 measure is changing into the W30 measure and will be strictly an administrative measure, no longer allowing for medical record review.
- Research on how to gain access to high volume provider offices' EMR system in order to locate member visit information more efficiently whether through Office Ally or other avenues.
- Develop crosswalk to identify potential member visits recorded under mother's CIN.
- Promote well-child visits through Bright Steps prenatal and postpartum calls through Post Bright Steps Well Baby Follow Up Call Project.
- Continue to incentivize well-child visits to providers in the 2021 P4V program, while exploring alternative member health reward options

Adolescent Well-Care Visits (AWC)

The table below shows a trend analysis for Medi-Cal HEDIS AWC for the MY2017–2019. The rates have steadily increased for AWC the past three years. However, a decline is anticipated in the 2020 MY rates due to observed dip in preventive care and well care visits during the COVID-19 pandemic.

AWC Table 1: MY2017–2019 Results: Medi-Cal
The rate for AWC is presented below, AWC met the 50th MPL at 57.0%, but did not meet the goal of 60.34%.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Adolescent Well-Care Visits (AWC)	54.26%	62.77%	68.14%	60.34%	MPL, P4V

2019 Adolescent Well-Care Initiatives: Medi-Cal

1. CalOptima Day Phase 1 04/17/2019–06/26/2019

A. Description

In an effort to impact adolescent well care visits, March, April and May 2019 prospective rates were pulled to provide offices with outreach lists to schedule members for CalOptima Day event.

B. Findings

1. A total of 18 CalOptima events focused on adolescent well-care visits. These events were held at 11 different clinic sites throughout Orange County.
2. The events yielded a potential of 625 HEDIS hits across the five pediatric HEDIS measures.
3. Based on the July 2019 prospective rates, 546 members fell into the AWC denominator, which yielded a potential of 373 potential hits for the AWC measure.

AWC Table 1. Measuring AWC rate improvement between July 2018 prospective rate and July 2019 prospective rate for CalOptima Day Participating Provider Offices

PROVIDER OFFICE NAME	AWC Rate Improvement
CHOC Orange Clinic	-4.84%
CLINICA CHOC Para Ninos	-2.66%
Gateway Medical Group*	-11.76%
Pediatrics & Neonatology	3.10%
San Juan Pediatrics	-1.84%
South Coast Pediatrics	-4.99%
StrongKids Medical Group**	5.43%
UCI FHC — Anaheim	3.35%
UCI FHC — Santa Ana	1.92%

* Gateway Medical Group events held at two different sites since members can be seen at either.
** StrongKids Medical Group events held at two different sites since members can be seen at either.

C. Analysis

1. There were 373/625 = 59.68% of the potential HEDIS hits for AWC.
2. On AWC Table 1, the majority of the clinics did not have an AWC rate improvement. However, AWC has the largest population out of the pediatric measures listed above, which allowed for an easier scheduling, but to impact rates it is more difficult.
3. The AWC denominator was too large to impact with limited events such as CalOptima Day. With many resources required, CalOptima Days are not recommended to try and impact the AWC measure. CalOptima Days should be limited to a very targeted HEDIS measure with a population (denominator) that is large enough for ease of scheduling but small enough to make a sizable impact on the rate.

D. Barriers

1. Scheduling was challenging for offices to get members in on the same day. No show rates were high.
2. Clinic administration buy-in was important. Clinics with a champion for this event tend to have a better outcome.
3. Learning curves during the planning stage of program.

E. Opportunities for Improvement

1. Stop CalOptima Days to impact the AWC measure.
2. Limit CalOptima Days to a very targeted HEDIS measure with a population (denominator) that is large enough for ease of scheduling but small enough to make a sizable impact on the rate.

2020 Adolescent Well-Care Initiatives: Medi-Cal

1. Annual Well-Care Visits 12–17 (AWC) Member Incentive Program 01/01/2020–current; and Health Guide 13–17 Newsletter Mailing with AWC Incentive Form 05/28/2020

A. Description

An AWC incentive was created to motivate an increase in AWC visits for all eligible Medi-Cal CalOptima members ages 12–17 years old. Requirement was to complete annual well-care visit and submit for a $25 gift card or three movie tickets. The incentive was mailed along with the Health Guide 13–17 newsletter on 05/28/2020 to 74,651 members who were identified as noncompliant for AWC based on February 2020 PR.

B. Findings

As of 10/15/20:

1. 8,301 AWC incentive forms have been processed
   - 6,771 AWC incentive forms have been approved = ~$169,275
   - 541 AWC incentive forms have been denied
   - 989 AWC incentive forms are pending
2. 224 members who submitted an AWC incentive form were a part of the Health Guide 13–17 newsletter and AWC Incentive Form mailing back in 5/28/20.

AWC Table 2. Annual Well Care Visits 12–17 Incentive Response Rate as of 10/15/20

Incentive Program	HEDIS MY2020 AWC Population	Total Incentive Submissions	Response Rate Based on Total AWC Population
AWC	**149,177**	**8,301**	**5.56%**

C. Analysis:

1. An unexpected large surge of incentives were submitted for the AWC incentive. Suspected reasons include the COVID-19 pandemic, in which medical office staff utilized available time to check on AWC visits already completed in 2020, to submit on behalf of members, during a time of financial insecurity. Instead of promoting utilization from historical non-compliant members, the COVID-19 climate ended up boosting incentive submissions due to the unique circumstances described above.
2. Approximately $169,275 was spent on AWC incentive. With a response rate of 5.56% the impact on HEDIS (if all submissions are accurate and claims are submitted correctly) will still remain minor due to the large denominator of 149,177.

3. Response rate for those included in the targeting mailing was 0.30% (224/74651).
4. For MY2020, the AWC HEDIS measure were revised into the Child and Adolescent Well-Care Visits (WCV) measure which combined the W34 and AWC measures and added the ages 7–11 years.

D. Barriers

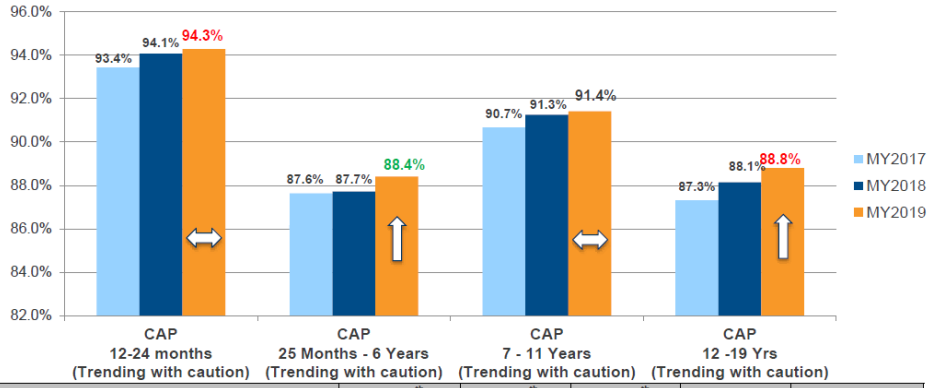
1. Recommendation for members to complete their annual well-care visit changed in March 2020 due to the COVID-19 pandemic. There was a period where adolescent annual well-care visits were not being scheduled as advised by the CDC. CalOptima's June 2020 Prospective rate reports show a decline when compared to the same time last year. June 2020 AWC PR 14.65%, June 2019 AWC PR 18.81%; declined 4.16% compared to last year.
2. Providers did not always use the right CPT code, or did not clearly distinguish between a sports physical exam and a comprehensive well-care visit.
3. Difficult to move the needle with such a large population like AWC.
4. Providers are not using AWC incentive as intended. Where the incentive was designed to motivate and promote future utilization by historical non-compliant members, providers were filling out the incentive form on the member's behalf and submitting it to CalOptima without the member's knowledge and requested that CalOptima not to send denial letters since members were unaware of the incentive.
5. After the mail drop on 05/28/20 to 74,651 members there was an influx of mailed-in incentive forms that were not filled out in its entirety or was filled out incorrectly. Members did not carefully read the instructions requiring an attested visit to be filled in by their provider. The denials and return process created an administrative burden.
6. The sheer volume of the denominator makes the program unstainable due to the drain on budgetary resources, processing burdens and ultimately a minor impact on the rates despite a relatively large volume of submissions. The year was not over and the expenditure was $169,275.

E. Opportunities for Improvement

1. Discontinue AWC incentive when the incentive period ends on 12/31/2020 due to the depletion of budget for member incentives, and an anticipated low impact on such a large numerator.
2. Stop doing targeted AWC mailings as the response rate was low (0.30%).

Children's Access to Primary Care Practitioners (CAP)

Performance Against Goal:
The rate for CAP and its submeasures is presented below. The 12–24 months and 12–19 years submeasures did not meet MPL. The 25 months–6 years and 7–11 years met the 50th percentile MPL. Only, 25 months–6 years CAP submeasure met goal of 87.87%. The 12–19 years submeasure is a P4V measure.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Children's Access to Primary Care Practitioners (CAP)					
12 - 24 Months	95.62%	97.04%	97.82%	95.62%	
25 Months - 6 Years	87.87%	90.32%	92.59%	87.87%	
7 - 11 Years	91.08%	93.41%	95.85%	92.33%	
12 -19 Years	90.21%	92.29%	94.64%	90.21%	P4V

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

2019 Children's Access to Primary Care Practitioners Initiatives: Medi-Cal

- Health Guide newsletter mailings discussed the importance of well-care visits, vaccinations, developmental milestones, healthy eating, care safety and other health education pertaining to the age group.
    - Health Guide 0–2 newsletter dropped 06/21/2019, targeted outreach to 10,991 members ages 0–2 years, who were due for CIS and/or W15.
    - Health Guide 3–6 newsletter dropped 07/10/2019, targeted outreached to 45,002 members ages 3–6 years, who were due for W34.
    - Health Guide 7–12 newsletter dropped 11/29/2019, targeted outreach to 14,975 members ages 12 years, who were due for AWC.
- CalOptima Day collaboration with HNs and provider offices hosted a health and wellness event focused on children and adolescents due for W15, W34, AWC, CIS and/or IMA.
    - Q2 2019 events: 11 sites participated, with a total of 18 events, which outreached to 870 members.
    - Q4 2019: three sites participated, which outreached to 129 members.
- Member incentive programs
    - Well-Child 4–6 Visits member incentive launched 09/01/2019. Incentive program awarded members $50 gift card to members ages 0–15 months old who completed at least six well-child visits before child's 15th month birthday. There were 276 total submissions.
        - Targeted Well-Child Visits 4–6 member incentive program mailing dropped 09/03/2019 and outreached to 1627 members who were identified as having an opportunity to complete six well-child visits before 15 months old.
- Provider incentive programs
    - Incentives were sent to 49 providers for participating in the Well-Child 4–6 Visits provider incentive program. Total payout for Q4 2019 is $9,550. Note: a few Q1 2020 was accidentally processed along with this batch.
- The 2019 Medi-Cal newsletter highlighted the *Don't Forget to Vaccinate, Get Shots at No Cost* article discussing the importance of well-care visits, immunization requirements for kindergarten and information on measles. The newsletter was mailed to 449,967 Medi-Cal members.
- Targeted W15 call campaign was conducted between 09/13/2019–10/04/2019 targeting members who have an opportunity to complete six well-child visits before turning 15 months old and to

promote the Well-Child 4–5 visits member incentive. There was 724 members who were outreached telephonically, with 574 successfully (live person or left voicemail).
- The W15 root cause analysis via survey to new mothers asking them where they took their children for their first two well-child visits and when. There were 94 call attempts made and with 31 successful live-person calls. Of that, 27 parents were able to recall a well-child visit date of service and 22 newborns had at least one well-child visit in the first three months of life.
- A fax blast was sent to 273 PCPs of members with outstanding W15 visits that explained the W15 HEDIS measure and the Well-Child 4–6 Visits incentive.

2020 Children's Access to PCP Initiatives: Medi-Cal

- Health Guide newsletter mailings discussed the importance of well-care visits, vaccinations, developmental milestones, healthy eating, care safety and other health education pertaining to the age group.
  - Health Guide 0–2 newsletter dropped 07/24/2020, with targeted outreach to 8,960 Medi-Cal members ages 0–12 months.
  - Health Guide 13–17 newsletter and AWC incentive mail dropped 05/28/2020, with targeted outreach to 74,651 members ages 13–17 years, who were due for AWC.
  - Health Guide 18–21 newsletter mail dropped 05/22/2020, with targeted outreach to 35,799 Medi-Cal members ages 18–21 years.
- IVR Call Campaigns
  - The W15 IVR call campaign slated for Q1 2020 was delayed due to COVID-19. Since Early and Periodic Screening, Diagnostic and Treatment (EPSDT) IVR campaign had similar messaging, W15 IVR was put on hold.
  - AWC IVR campaign slated for Q2 2020 was put on hold due to COVID-19. Messaging does not currently align with best practices during the pandemic.
  - EPSDT IVR campaign slated for Q3 2020 was put on hold. Messaging promoted preventative care to Medi-Cal members ages 0–2 and 3–6 years.
- Communications
  - Included *Well-Child Visits During COVID-19 Pandemic* article in the May Provider Update discussing the importance of continuing well-child visits during the pandemic in accordance with AAP guidelines. Care for newborns and well visit and immunizations of infants and young children (through 24 months of age) are prioritized.
  - Included *2020 CalOptima Member and Provider Incentive Programs* article in the July Provider Update. Article discusses CalOptima's PHM incentive opportunities, clarifies incentive eligibility requirements, and reiterates the W15 member and provider incentive criteria.
  - Promoted the Health Guide 13–17 and Health Guide 18–21 newsletter via Community Connections in July 2020.
  - Launched *Don't Wait—Vaccinate*, immunization campaign and article promoting vaccinations during the pandemic on the CalOptima website, went live 08/21/2020.
  - Included *Well-Care Visits and Vaccinations During a Pandemic* in the Orange County Immunization Coalition Summer newsletter

- **Incentives**
  - Well-Child Visits 1–3 (W15) member incentive program for Medi-Cal members who completed at least 3 well-child visits in the first 6 months of life received a $50 gift card.
  - Well-Child Visits 4–6 (W15) member incentive program for Medi-Cal members who completed at least 6 well-child visits by their 15-month birthday received a $50 gift card.
  - Well-Child Visits 1–3 and Well-Child Visits 4–6 provider incentive of $50 for each completed incentive form for eligible members.

    - Annual Well-Care Visits 12–17 (AWC) member incentive program launched January 2020 for Medi-Cal members who need to complete their annual well-care visit.

- CHOC Health Alliance held CalOptima Day Events 03/04/2020–03/05/2020 which focused on well-care visits for members due for either W15, W34 or AWC. There were 125 CalOptima Medi-Cal members that received service.
- September 2019 launched Post Bright Steps Well Baby Follow-Up Call project. After a mother graduates from BSP and completed the Postpartum Assessment, the Bright Steps team created an activity to follow-up with the baby in either two weeks or when baby was three months old depending on their risk level.

Barriers
- Due to the COVID-19 pandemic, there was a drop in PCP visits starting March 2020. Recommendation for provider offices visits changed. CalOptima's June 2020 Prospective rate reports show a decline when compared to the same time last year. The community was reluctant to go in for their preventive care screenings due to COVID-19.
- Preventative care visits were prioritized for pediatric members 0–2 years old during the pandemic and extended to populations who were due for their vaccinations.
- CAP measure was directly associated with other pediatric measures such as, but not limited to: W15, W34, AWC and WCC. Since other measures have been impacted due to COVID-19, CAP measure shows a decline as well.

Opportunities for Improvement
- The CAP measure were retired by NCQA.
- Focus on other pediatric measures which align with CAP measure parameters.

Overall Evaluation of Quality Initiatives

In 2019 and 2020, quality initiatives were numerous and required many resources. While there were many interventions and activities, not all efforts yielded the maximal return on investment. Some of the more resource-intensive initiatives did have merit. Events such as the CalOptima Days — while staff, time and financially resource-intensive — produced real qualitative benefits including more hands-on engagement with HN quality administrators. The W15 member and provider incentive required overall much more interaction with provider offices, to provide clarification and explanation of the incentive specifications as well as HEDIS requirements. This created opportunity to clarify the well-care visit schedule expectations that would meet the W15 acceptable timeline to satisfy the measure requirements. As a result, some providers changed their appointment schedules in response to that clarification. In addition — especially during the 2020 pandemic period — preliminarily, the engagement in member and provider incentives showed a surge whether it was due to an additional financial need created because of the economic ramifications or whether members and providers became more mindful of health opportunities and also had more time to address them. Furthermore, many provider offices which submitted incentives on behalf of their patients explained that they had more time due to the lull in patient flow, which allowed them to review patient charts and submit incentives on their behalf. We can only assume that member experience has likely significantly improved due to the increased number of rewards mailed to members during the pandemic.

In spite of some of these benefits to some of these more resource involved initiatives, it is clear that the impact on the HEDIS numerator (which closes a gap in member care) for many of these

measures were not impacted in measure to the efforts expended. CalOptima Days required heavy staff, financial and time investment, however, the number of hits that would affect HEDIS were comparably low to the resources invested. Events such as the Mobile Mammography brought high value with member experience to CCN members, however, each event was resource intensive, requiring staff across multiple departments to do outreach calls and make arrangements with the vendor as well as finding the community location that would be the best fit. It is not to say, that the impact on the numerator is the ultimate goal for each initiative, however, there must be a consideration of all factors involved to determine which initiatives to put resources towards in the next work plan year with limited resources.

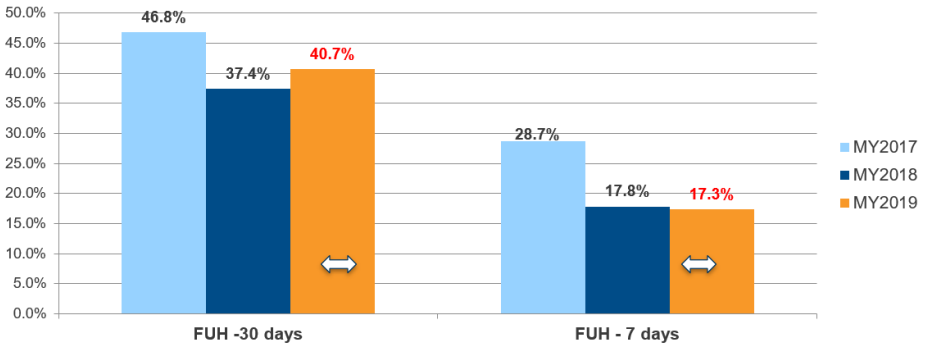
Probably the heaviest lift in 2019 and 2020 were the renovation and addition of new member and provider incentives. In making changes to existing incentives — and adding the W15, the AWC Medi-Cal incentives, and the Colorectal and Breast Cancer Medicare health rewards — the internal effort affected every QI work team from defining the parameters, revising content, program design, graphic design, promotion and marketing to the creation of an ever-evolving internal database to track all incentives efficiently. The largest unexpected burden was the incentive processing which was not anticipated to be as burdensome as it was in execution. The especially large and constant influx of AWC member incentives required the involvement of 12–15 other departmental staff in various capacities to tackle the processing requiring overtime hours. The department is preparing for an incentive RFP to select a member health rewards vendor to open up solutions for a more comprehensive gaps in care overall quality initiative to be developed with a multi-prong communication and member engagement plan.

Overall, in view of the many increases and improvements seen across priority measures, the strongest recommendation is for the focus and efforts be primarily channeled into the improvement of data exchange between CalOptima and all contracted HNs, providers and labs. The exchange of data sparked opportunities for discussion of expectations and sharing of how best to utilize data available at both the provider and health plan level. Through significant efforts to bridge data gaps for W15, connecting the mother's CIN with her child's well-care visits and obtaining much needed supplemental data was vital to the improvement of rates.

In the next HEDIS year, many of the measures previously hybrid in nature, will be changing into administrative only data opportunities. The need to address significant gaps and missing data especially in terms of lab data and early well care visits will be vital in helping CalOptima remain performing at or above a MPL for DHCS MCAS measures and for established goals. Access to electronic medical record systems for contracted HNs whether through Office Ally or other contracted means will not only open up CalOptima's access to much needed encounter data but should also help remedy the lab data gap which is not currently obtained through current limited lab contract data exchanges. Addressing the data gaps will also provide us with accurate and timely information to plan and develop targeted initiatives to the appropriate populations.

Behavioral Health Quality Initiatives

Follow-Up After Hospitalization for Mental Illness (FUH)



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	46.16%	59.74%	71.43%	56.00%	CMS, Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	24.79%	34.33%	45.62%	18.20%	CMS

*Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure
↑ ↓ statistically higher or lower ↔ statistically no difference

Completed Activities in 2020

- In Q1 2020, the Behavioral Health Integration (BHI) management team in partnership with Network Relations visited the top three hospitals with inpatient psychiatric admissions to discuss concurrent review and transition of care management process. The team educated hospital staff about CalOptima's resources and expectations.
- BHI created and implemented a personal care coordinator position to conduct member outreach after member is discharged from hospital to coordinate follow-up appointments. The personal care coordinator also assisted members in securing a follow-up appointment if necessary.
- A report was developed based on data in Guiding Care to track the personal care coordinator outreach activities and post discharge follow up visit in real time. When members did not have a follow up appointment within seven days of discharge, the personal care coordinator outreached to members to identify barriers and secure a visit within 30 days.

A Transition of Care Management (TCM) team was created to building and maintain relationships with hospitals. The team meets with the Behavioral Health (BH) Medical Director weekly to discuss concurrent reviews and internal coordination interventions.

- Credentialed HCA providers who were qualified to provide Medicare covered BH services.

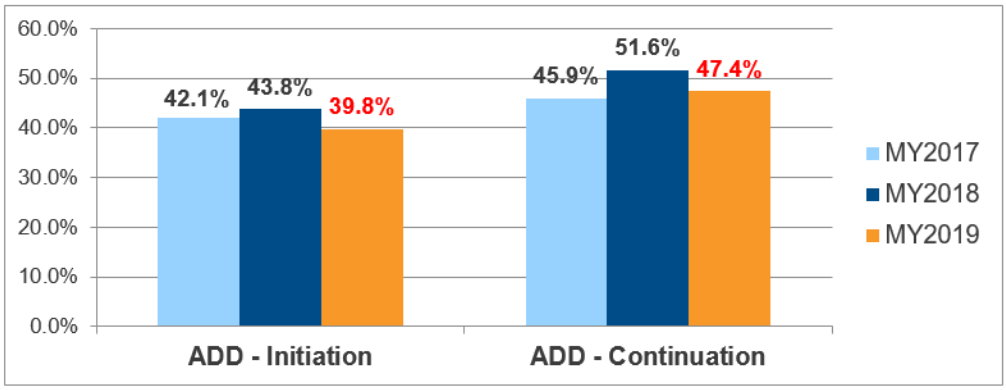
Barriers

- The discharge planning procedure is not standardized among the hospitals that serve our members. In addition, some hospitals lack understanding of the HEDIS requirements for FUH.
- The personal care coordinator was not always able to contact members after they have been discharged from the hospital — particularly if they are homeless or did not provide the hospital with their most current contact information.
- CalOptima is not able to credential some HCA providers due to the board certification requirement. As a result, the County has not been able to bill CalOptima for some of the outpatient psychiatric care provided at county clinics.

Opportunities for Improvement

- The BHI department implemented several virtual care strategies, including eVisits and telehealth, that helped expand access to behavioral health services. Those strategies offer members more options for follow up visit to meet their needs.
- The TCM team will continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment.
- The BHI management team will conduct additional hospital visits to educate discharge planning staff about FUH requirements and address any questions or concerns.

Follow-Up Care for Child ADHD (ADD)



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	43.41%	49.86%	56.57%	48.00%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	55.50%	62.69%	69.15%	55.50%	ACC, RS

*Red = less than 50th percentile, Green= met goal,
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2020

1. BHI created a report to track/trend providers who are non-compliant with this measure. Providers with high frequency of non-compliance were sent a letter to inform them about ADD requirements and the importance of follow-up visits with patients prescribed with ADD medications.
2. The provider education letter was updated to include more details about the requirements and the rationale for follow-up visits.

Existing Barriers

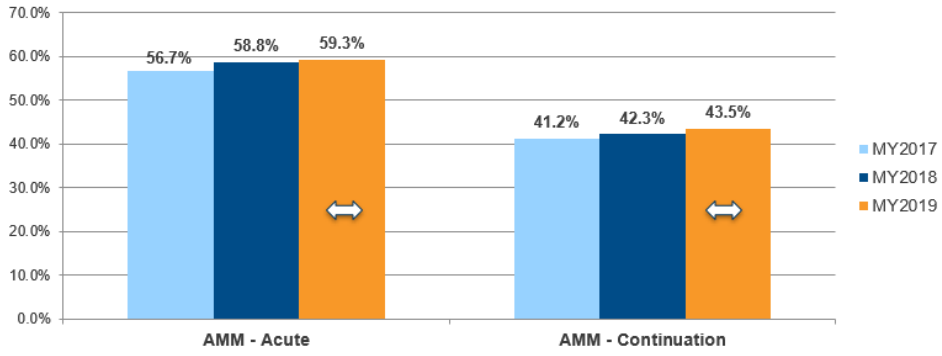
1. The provider letter was mailed to the address on record. We discovered that some of the letters went to an administrative office, which the provider may not be at that location. Also, a few of the letters were returned to CalOptima due to wrong address.
2. We are also aware that providers receive many materials from health plans and other businesses. It is possible that not all providers will read the letter or pay close attention to it; therefore, reducing the overall impact of the intervention.

Opportunities for Improvement

1. The BHI Quality team will continue to send letter to providers who are not meeting the ADD requirements.
2. Providers can schedule an appointment with members who need ADD follow up visit. However, members might have other reasons for not showing up for the appointment. The BH Quality team will explore opportunities to conduct member outreach to identify barriers and assist member with appointment scheduling if necessary.
3. Some of the ADD materials have not been updated for several years. Once updated, the team will distribute the new materials to providers and members as part of the outreach effort.

Antidepressant Medication Management (AMM)

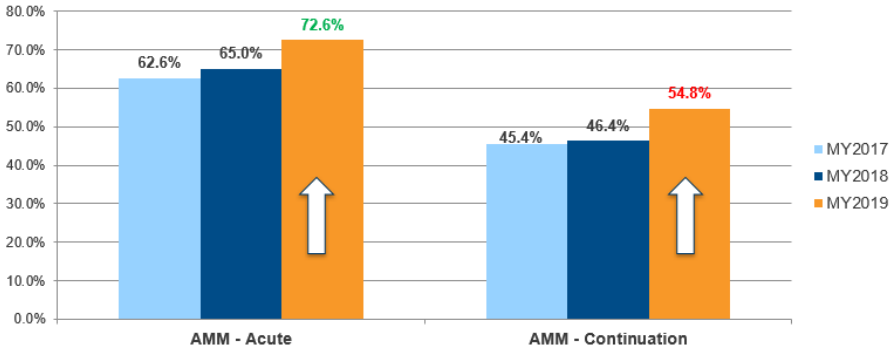
Medi-Cal AMM



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	52.33%	56.41%	65.95%	61.18%	MPL
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	36.51%	40.95%	48.68%	44.82%	ACC, RS, MPL

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

OCC AMM



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	71.60%	77.19%	83.33%	66.91%	CMS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	56.17%	61.31%	67.07%	50.39%	CMS

*Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure
↑ ↓ statistically higher or lower ↔ statistically no difference

Back to Agenda

Completed Activities in 2020

1. The BHI quality team reviewed and updated educational brochure for members on depression and treatment compliance.
2. The development of the Living with Depression video posted on CalOptima's website as part of the Health and Wellness Self-Care Guides for members.

Existing Barriers

1. It became apparent after updating the English version of the depression brochure, that a direct translation of the content to other languages may not meet the needs of various ethnic groups.
2. Members attending doctor appointments via telehealth; therefore, unable to pick up the brochure
3. BHI staff had multiple meetings with Provider Relations (PR) department to discuss the distribution of the brochure. Several challenges were identified including:
    - Temporary closure of providers' offices
    - PR staff not conducting in-person visits

Opportunities for Improvement

1. Offer digital version of the depression brochure to providers so they can share and discuss the material with members during telehealth visit.
2. Develop culturally appropriate version of the depression brochure for various ethnic groups.
3. Develop a HEDIS reporting tip sheet to educate providers about AMM requirements.
4. Educate members about the importance of depression medication adherence via member newsletters and social media.

Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. DSF requires providers to screen patients ages 12 years and older for clinical depression using standardized depression screening tools AND if positive, provide and document a follow up plan. Since DSF is still a relatively new measure, there is currently no benchmark to evaluate performance. CalOptima had been tracking the measure and conducted improvement activities.

Completed Activities in 2020

1. Depression screening, i.e. PHQ9, was completed as part of CalOptima's health needs assessment (HNA) for Whole-Child Model, complex case management, and care coordination.
2. Successfully loaded PHQ scores recorded in our Medical Management system to HEDIS software.
3. The BHI quality team updated the depression brochure which will be used as outreach material for members and providers.
4. The development of the Living with Depression video posted on CalOptima's website as part of the Health and Wellness Self-Care Guides for members.

Existing Barriers

1. It became apparent after updating the English version of the depression brochure, that a direct translation of the content to other languages may not meet the needs of various ethnic groups.

2. The number of provider educational events dropped significantly due to COVID-19. As a result, there was no opportunity to promote depression screening and treatment in the community.
3. Fewer members are scheduling routine care visits (i.e. well child visit, annual physical exam) resulting in fewer opportunities for providers to conduct depression screenings.

Opportunities for Improvement

1. Develop member information encouraging them to schedule routine/annual visits to increase opportunities for depression screenings.
2. Develop culturally appropriate version of the depression brochure for various ethnic groups.
3. Develop a HEDIS reporting tip sheet to educate providers on the importance of depression screening, available screening tools, and treatment options.
4. Explore ways on how to incorporate tools into CalOptima's internal system to gather data from providers.
5. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

Transition of OC and OCC Behavioral Health

In May 2019, CalOptima's Board of Directors approved transitioning OC and OCC BH services from Magellan to CalOptima. Multiple departments were involved in the implementation including Contracting, Provider Relations, Claims, Customer Services, BHI, Information Services, UM, RAC, and Process Excellence. On January 1, 2020, CalOptima started managing OC and OCC BH services including inpatient psychiatric care, outpatient behavioral health services, and opioid treatment program services. CalOptima was able to directly contract with most of the providers who were seeing our members through Magellan. Providers also had the option to sign a Letter of Agreement (LOA) to continue to see our OC and OCC members if they chose not to contract with CalOptima. The CalOptima BH Line leveraged existing protocols to manage OC/OCC BH calls. Overall, the transition went smoothly with minimal disruption to members care.

Safety of Clinical Care

Opioid Utilization

Opioid Utilization Data 2019–2020 Results

CalOptima Medi-Cal Opioid Analgesic Utilization	2019-Q3	2019-Q4	2020-Q1	2020-Q2	2020-Q3	% Change 3Q19 to 3Q20
Opioid Analgesic Rxs	38,426	35,927	33,616	31,268	34,530	-10.1%
% Members Utilizing Opioid Analgesic Rxs	1.09%	1.01%	0.99%	0.88%	0.97%	-11.3%
Opioid Analgesic Rxs PMPQ	0.021	0.020	0.019	0.017	0.018	-12.3%
Members Receiving > 80mg Avg MME	604	537	487	456	457	-24.3%

% Utilizing Members Receiving > 80mg Avg MME	3.01%	2.88%	2.78%	2.88%	2.50%	-16.7%
Average Quantity/Rx for Short-Acting Opioid Analgesics	51.7	52.0	52.6	54.6	51.0	-1.3%

CalOptima Opioid Utilization Goals	2019-Q3	2019-Q4	2020-Q1	2020-Q2	2020-Q3
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	13.1	12.3	12.0	11.4	10.9
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	2,639	2,469	2,362	2,179	2,391

CMS Medicare Star Display Measures

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D): Multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer and not in hospice care.

- Measure 1: Use of Opioids at High Dosage (OHD): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer.
- Measure 2: Use of Opioids from Multiple Providers (OMP): Members receiving prescriptions for opioids from four or more prescribers AND four or more pharmacies.
- Measure 3: Use of Opioids at High Dosage and from Multiple Providers (OHDMP): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies.

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage in Persons without Cancer	OneCare	2%	7%	Equal or Better
Use of Opioids at High Dosage in Persons without Cancer	OCC	5%	7%	Equal or Better

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids from Multiple Providers	OneCare	0%	0%	Equal or Better

Use of Opioids from Multiple Providers	OCC	1%	0%	Equal or Better

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage and from Multiple Providers	OneCare	0%	0%	Equal or Better
Use of Opioids at High Dosage and from Multiple Providers	OCC	0%	0%	Equal or Better

* *Medicare-Advantage Prescription Drug*

Completed Pharmacy Management Interventions in 2020

Prescriber

1. Quarterly prescriber report card: Intervention provided to providers whose average Milligram Morphine Equivalent (MME) dose per prescription fell above their practice specialty average.
2. Prescriber newsletters:
    - FDA Warning of Respiratory Depression for Gabapentinoids with Concomitant Opioids
    - Opioid Quality Measure Update
3. Monthly Medicare Opioid Overutilization Intervention: Member opioid and benzodiazepine medication list faxed to most recent prescriber of members who meet CMS Opioid Monitoring System (OMS) Criteria.

Pharmacy

1. Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection (overridable by the pharmacist) and exceeding 400mg will trigger a hard rejection (authorization required).
2. Point of service soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

Member

1. Retrospective identification of members meeting criteria for opioid overutilization for Medical Director Review and referral to Compliance, QI or Case Management.
2. Pharmacy Home Program Policy: Members filling prescriptions at four or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
3. Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the members filling controlled substance prescriptions from four or more prescribers in a two month period are restricted to designated prescribers.

Formulary

Medi-Cal

1. Point-of-sale (POS) pharmacy edits triggering a soft rejection for opioid pharmacy claims attempted to be filled within 30 calendar days of a fill for buprenorphine-containing products.
2. Require prior authorization for new starts for methadone doses above 30mg/day.
3. Require prior authorization for new starts for all long-acting opioids.
4. Stricter quantity limits for short-acting opioid analgesics.
5. Concurrent use of opioids and opioid potentiators (such as benzodiazepines or gabapentinoids) formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate National Council for Prescription Drug Programs (NCPDP) codes upon review of drug therapy.

Medicare

1. Hard safety edit to limit initial opioid prescription fills to no more than a seven-day supply.
2. Pharmacist-driven care-coordination formulary safety edit for duplicative long-acting opioid therapy (excluding buprenorphine) with a prescriber count of at least two prescribers that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

3. Pharmacist-driven opioid care coordination formulary safety edit would trigger when a member's cumulative MME per day across all opioid prescriptions reaches or exceeds 90 MME.
4. Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Existing Barriers

1. Lack of timely data from DHCS for Medication Assisted Therapy (MAT) medication carve out claims for Medi-Cal members.
2. No access to data for medications dispensed by Opioid Treatment Programs (OTP).

New Opioid Interventions Completed in 2020

1. Effective October 1, 2019, CalOptima's Medi-Cal DUR program complies with section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS: opioid pharmacy claims for members shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/day without prior authorization.
2. Promote Medication Assisted Therapy (MAT): The use of FDA-approved medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
3. Contract with OTP for Medicare members effective January 1, 2020.

In 2021, the Medi-Cal outpatient pharmacy benefit will be carved out to the state. There are no planned interventions at this time.

Post-Acute Infection Prevention Quality Incentive (PIPQI)

PIPQI is a CalOptima quality initiative program shown to reduce antibiotic-resistant bacteria in hospitals and nursing homes. Participating nursing facilities utilize chlorhexidine (CHG) bath soap for all baths and showers and Iodophor nasal swabs bi-weekly. Currently, 26 nursing facilities participate in PIPQI. CalOptima nurses monitor compliance with CHG and nasal swab usage, Hospital Acquired Infection (HAI) scores, and hospital admissions/readmissions due to infections.

COVID-19 presents the following barriers:

- Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.
- High turnover rates in facilities creates a need for constant PIPQI training.
- Due to COVID-19, CalOptima nurses are not allowed to conduct on-site visits for monitoring or training of facility staff.

CalOptima nurses began monitoring compliance with PIPQI via telephone in March 2020, conducting phone consultations and training. One training video per month is reviewed with all participating nursing facilities. Quality performance measures will be monitored in 2021. PIPQI will be made available to additional facilities per request of facility in 2021. Consultation and training will continue via telephone and webinar until CalOptima nurses can resume on-site visits to nursing facilities.

Additionally, CalOptima partnered with HCA and University of California, Irvine (UCI) to implement the OC Nursing Home COVID-19 Infection Prevention Training Program. Aimed at keeping patients, staff and families as safe as possible during the pandemic by preventing virus spread. Program includes intense in-person training of 12 CalOptima contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima OC contracted nursing facilities.

Goals:

- Outfit OC nursing homes to prevent COVID-19 as soon as possible, but especially in time for fall surge.
- Provide expertise on infection prevention for COVID-19/SARS-CoV-2.
- Provide guidance, protocols for preventing spread of COVID-19.
- Support training on how to stock and use protective gear.
- Develop high compliance processes for protection of staff and residents.

Program was implemented in June 2020 and will run through May 2021. On average, approximately 60 people attend the webinars from approximately 20 nursing facilities. Training materials can be found at uci.org/stopcovid

2019–2020 Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects for 2019–2020 by each improvement project type.

QIPs: OCC Population and NCQA Patient Safety Standard – Medi-Cal

1. Improving Statins Use for Patients with Diabetes (SPD) 2019–2020

The improving statin use for patients with diabetes mailing intervention targets all three LOBs; Medi-Cal, OC and OCC. The Medi-Cal results will be reported to NCQA to satisfy the Patient Safety standard. OCC results will be reported to CMS as part of a QIP. There is no QIP requirement for the OneCare population however CalOptima chose to still include this small population as part of the SPD intervention.

Goal
To increase statin use among members with diabetes by 5%.

Target Population
All CalOptima members who are diagnosed with diabetes.

Interventions
A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima members diagnosed with diabetes. An SPD member mailing was sent in tandem with an existing provider focused program to promote statin use among members diagnosed with diabetes and to encourage members to have a discussion with their health care providers about whether a statin is right for them.

Activities
Quarterly mailings and the IVR messaging campaign promoting the discussion with their providers have been put into place to encourage members to consider the potential benefits of preventing cardiovascular complications.

Mailing Summary
Program implemented in Quarter 4, 2019. Data collection is in ongoing for all three LOBs.

SPD Member Quarterly Mailings						
	Q1 2020			Q2 2020		
LOB	Member Count	Members Eligible Sent	Members Received Intervention	Member Count	Members Eligible Sent	Members Received Intervention
OneCare	87	40	32	61	8	5
OCC	761	276	146	630	125	46
Medi-Cal	6150	2334	1006	5320	1007	278
Total	**6998**	**2650**	**1184**	**6011**	**1140**	**329**

2019 Interactive Voice Recording (IVR) A1c and Statin Use Campaign				
Disposition	Medi-Cal	OneCare	OCC	Grand Total
Successful IVR call	17001	121	1033	18155
Unsuccessful IVR call	35101	148	2174	37423

Overall, we had a 32.67% successful IVR call rate across all three LOBs. Members were contacted telephonically via robocall with a message emphasizing the importance of scheduling an A1C test and promoting the discussion of statin use with their health care providers to reduce cardiovascular complications.

Performance Improvement Projects (PIPs)

1. **OCC PIP: Members with Individualized Care Plan Completed/Members with Documented Discussions of Care Goals 2018–2019 Completed April 2020**

Goals

1. CA 1.5 – Members with an Individualized Care Plan Completed
   Year 1 Goal: High Risk: 48.89%; Low Risk: 38.81%
   Year 2 Goal: High Risk: 52.09%; Low Risk: 41.06%

2. CA 1.6 – Members with Documented Discussions of Care Goals
   Year 1 Goal: 77.91%
   Year 2 Goal: 81.57%

Interventions

1. Change language with Health Risk Assessment (implemented 1/3/18)
2. Initiate Initial Care Plan (ICP) discussion goals at the first contact with member

Summary of Results

Study Indicator 1	
Study Indicator 1 Title	CA 1.5 High Risk with an ICP completed. (56.45%)
Measurement Year Goal	52.09%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	High Risk (B/A) Quarter 1: (2019) 53.23% (PDSA cycle 4) Quarter 2: (2019) 54.57% (PDSA cycle 5) Quarter 3: (2019) 55.68% Quarter 4: (2019) 56.45%
Study Indicator 2	
Study Indicator 2 Title	CA 1.5 Low Risk with an ICP completed. (68.48%) – 90 days continuous enrollment
Measurement Year Goal	73.48%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	Low Risk (D/C) Quarter 1: (2019) 41.87% Quarter 2: (2019) 43.03% Quarter 3: (2019) 43.70% Quarter 4: (2019) 44.45%
Study Indicator 3	
Study Indicator 3 Title	CA 1.6 OCC Members with Documented Discussion of Care Goals (74.81%)
Measurement Year Goal	81.57%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 3) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 4) Quarter 3: 07/01/2019 to 09/30/2019 (PDSA cycle 5) Quarter 4: 10/01/2019 to 12/31/2019

Results	Quarter 1: (2019) 93.01% (PDSA cycle 3) Quarter 2: (2019) 90.21% (PDSA cycle 4) Quarter 3: (2019) 91.02% (PDSA cycle 5) Quarter 4: (2019) 92.19% Cumulative Rate (up to end of each cycle/quarter): 1/1/18–3/31/19: 93.01% 1/1/18–6/30/19: 91.55%

For study indicators 1 and 2, changes made to our data collection process in response to regulatory guidance to only count care plans that had proof of member involvement resulted in a change to our data collection process. Our prior process did not have a positive review question that addressed member involvement. When we made the change, it allowed us to collect data specifically aimed at that question for each quarter going forward. However, since this is a cumulative measure, and the target criteria have been modified, when we applied the same logic, we lost the ability to count many care plans that were created prior to the question being implemented.

The CA 1.5 High-Risk rate improved from 52.09% in 2018 to 56.45% in 2019 for an increase of 4.36 percentage points. The 2019 rate of 56.45% was 7.56 percentage points higher than the goal rate of 48.89%. This showed sustained and increasing improvement. Because of the large numbers in the numerator and denominator Fisher's exact test was not performed, but Chi-Square without Yates' correction was used instead (Chi-Squared equals 20.804 with 1 degrees of freedom). The test's two tailed p-value was less than 0.0001 and yielded an extremely statistically significant outcome.

The CA 1.5 Low-Risk rate improved from 41.06% in 2018 to 44.45% in 2019 for an increase of 3.39 percentage points. The 2019 rate of 44.45% was 5.64 percentage points higher than the goal rate of 38.81%. This showed sustained and increasing improvement. Because of the large numbers in the numerator and denominator, the Fisher's exact test was not performed but Chi-Squared without Yates' correction was used instead (Chi-Squared equals 1516.833 with 1 degrees of freedom). The test's two tailed p-value was less than 0.0001 and yielded an extremely statically significant outcome.

For study indicator 3, results continue to show strong improvement, with Q3 results indicating that 91.02% of members had discussions of care goals. In Q4, we achieved the rate of 92.19%, which exceeds our goal of 81.57%.This intervention is proving to be effective and will be continued.

CalOptima has satisfied all requirements for the OCC ICP PIP. We have demonstrated statistically significant improvement for two consecutive years for this PIP. This PIP project was completed and closed out in April 2020.

2. Medi-Cal PIP: Improving Well-Care Visits for Children in Their First 15 Months of Life (W15) for CalOptima Medi-Cal Members with Provider Office A

Goal
By June 30, 2021, increase the percentage of well-child visits among Medi-Cal members turning 15 months old for Provider Office A, from 41.51% to 51.61%.

Proposed Interventions
Provider and member incentive to increase well-child visits in the first 15 months of life.

1. Member incentives:
    - $50 for completed well-child visits 1-3
    - $50 for completing well- child visits 4-6
2. Providers are to receive the same amount verified through claims and encounters.

DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project. Awaiting guidance from DHCS to establish new PIP requirements at the end of 2020.

3. **Medi-Cal PIP: Improving Access to Acute/Preventive Care Services to Medi-Cal Members Experiencing Homelessness in Orange County.**

Goal
By June 30, 2021, increase the rate of acute and or preventive care services among Medi-Cal members 18 years and older identified as experiencing homelessness in Orange County from 41.8% to 43.2%.

Proposed Interventions
Implementing HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.

DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project. Awaiting guidance from DHCS to establish new PIP requirements at the end of 2020.

CCIPs: OC and OCC and NCQA Emerging Risk Standard – Medi-Cal

Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8%

The improvement project targeting the emerging risk populations aimed at improving A1C Control <8% for Members Recently Experiencing Poor Control >8%. This intervention targets Medi-Cal, OC and OCC. The Medi-Cal results will be reported to NCQA to satisfy the Emerging Risk standard. The OC and OCC results will be reported to CMS as part of a CCIP.

1. **OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021**

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OC members identified and who participate back to an A1C <8% within one year.

Target Population
OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

- Exclusion criteria:
  - Ineligible CalOptima members
  - Members identified for long-term care (LTC) or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets OC members with diabetes with A1C results trending upward from <8% to >8%. OC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results: The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (OC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached	Emerging Risk Members Incomplete Assessment	No Longer Eligible
2020	Q1	OC	0	0				
2020	Q2	OC	8	0	0	0	0	0

In Q1 2020, there were no OC members that were assigned to a health coach. (Only one member at the time and was recently outreached by a health coach on 12/31/2019.) For Q2 2020, there was eight in the starting denominator, but none were assigned due to accidentally assigning the Medi-Cal and OCC members first. Will prioritize OCC members first for Q3 2020.

2. OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2020

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an A1C <8% within one year.

Target Population
OCC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members were enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
- Exclusion Criteria:
  - Ineligible CalOptima members
  - Members identified for LTC or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets OCC members with diabetes with A1C results trending upward from <8% to >8%. OCC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results
The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached	Emerging Risk Members Incomplete Assessments	No Longer Eligible
2020	Q1	OCC	4	4	2	0	0	0
2020	Q2	OCC	85	8	6	1	1	0

In Q1 2020, 4 members were assigned to a health coach and 2 were successfully outreached telephonically. In Q2 2020, 8 members were assigned to a health coach and 6 were successfully outreached telephonically.

3. Medi-Cal CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to Medi-Cal members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of Medi-Cal members identified and who participate back to an A1C <8% within one year.

Target Population
Medi-Cal members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
- Exclusion Criteria:
  - Ineligible CalOptima members
  - Members identified for long-term Care (LTC) or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets Medi-Cal members with diabetes with A1C results trending upward from <8% to >8%. Medi-Cal members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned

approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results
The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (Medi-Cal)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached (#5 Yes)	Emerging Risk Members Unsuccessfully Outreached (#5 No)	Emerging Risk Members Incomplete Assessments	No Longer Eligible
2020	Q1	Medi-Cal	148	143	39	5	1	0
2020	Q2	Medi-Cal	731	35	22	1	12	0

In Q1 2020, 143 members were assigned to a health coach and 39 were successfully outreached telephonically. In Q2 2020, 35 members were assigned to a health coach and 22 were successfully outreached telephonically. We will continue to track and monitor this CCIP.

PDSA Initiatives

1. PDSA – Improving Flu Vaccination Rates for the Medi-Cal Population

In September 2020, DHCS required all MCPs to conduct a PDSA rapid cycle project on a single performance measure of the MCPs/PSPs choice that focuses on a preventive care, chronic disease management, or behavioral health MCAS measure impacted by COVID-19. MCPs/PSPs should provide evidence to support their choice of PDSA topic. DHCS will be flexible on the format and types of interventions for the PDSA cycles to accommodate for COVID-19 barriers. CalOptima has chosen to improve the Adult Immunization Status (AIS) measure, with a focus on influenza vaccinations. We are currently working the planning portion of this project. This PDSA will continue through the end of 2021.

2. Initial COVID-19 QIP Submission

In September 2020, DHCS required all MCP/PSP plans to submit a brief COVID-19 QIP to DHCS. The initial COVID-19 QIP (due to DHCS on October 2, 2020) submission included a description of the MCP's/PSP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care, for members amidst COVID-19. The second COVID-19 QIP submission (due to DHCS on March 1, 2020) should include a six-month progress update on the interventions and/or strategies. CalOptima has submitted the initial response back to DHCS on October 2, 2020.

SECTION 3: QUALITY OF SERVICE

Member Experience

CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

CalOptima monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and HN. The achievement score is the calculation of positive responses, typically identified as "Usually" or "Always" or rated top scores of "8, 9 or 10."

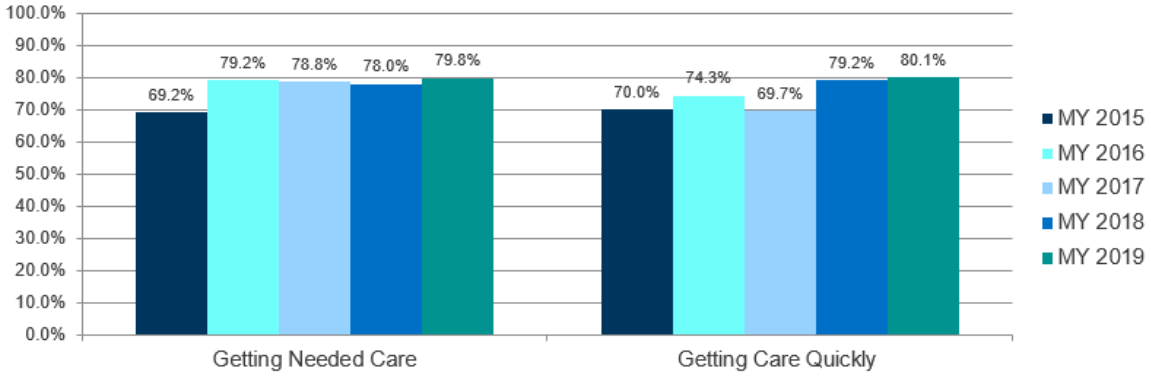
In early 2020, the world was struck by the COVID-19 pandemic. By mid-March, the state of California was under a state-wide lockdown (shelter-in-place) order. The CAHPS vendor's call center was closed and the vendor was unable to conduct the telephone follow-up calls. To address this issue, the survey protocol was modified from two mailings with a telephone follow-up to three mailings. While CalOptima's CAHPS survey still yielded approximately a 20% response rate, it's impossible to predict the effects of the pandemic on the survey results and survey results and any comparisons to trend data should be viewed with caution.

CAHPS Trend Analysis
CalOptima identified that the "Getting Needed Care and Getting Care Quickly" measures were consistently performing below goal. The following tables includes the plan level survey achievement scores for the adult and child surveys for two key measures (i.e. getting needed care and getting care quickly).

See next page for results.

Goal
To meet the 50th percentile when compared to National Medicaid Benchmarks.

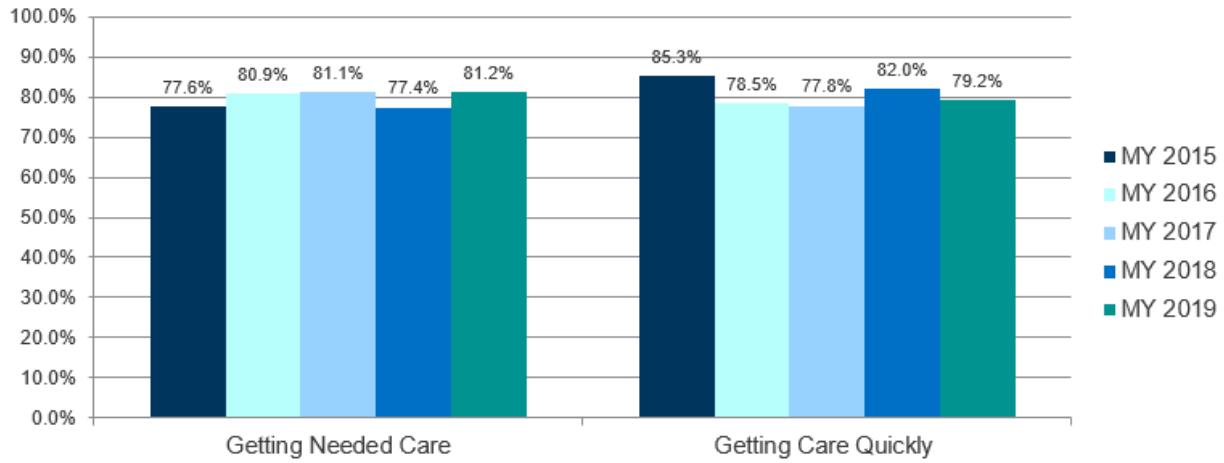
Medi-Cal Adult CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

Medi-Cal Child CAHPS Survey Results

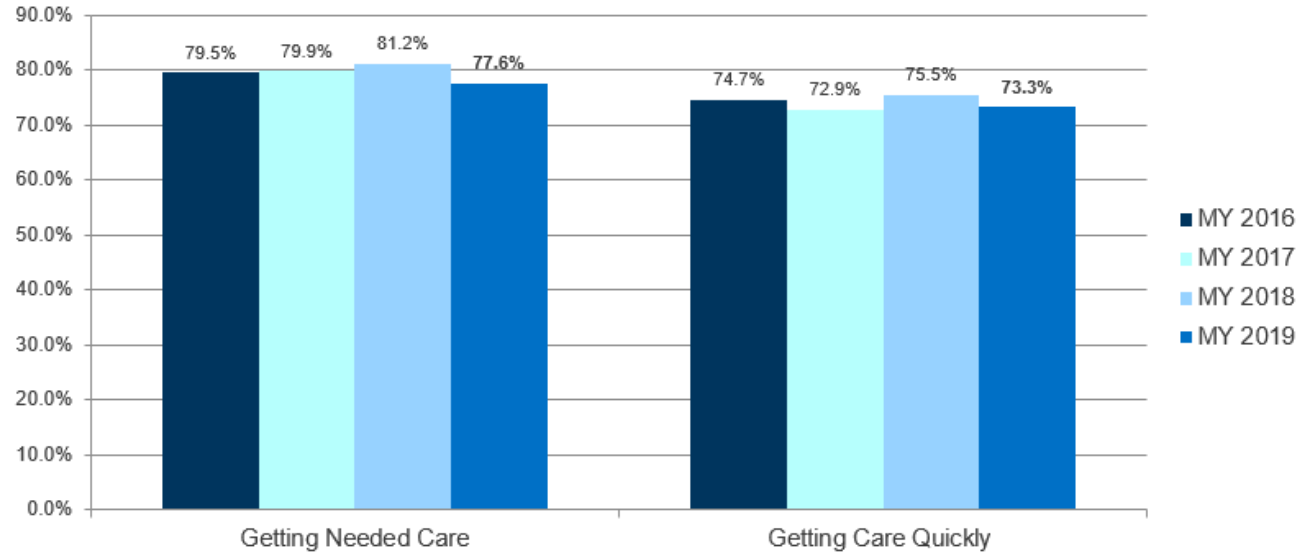


National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

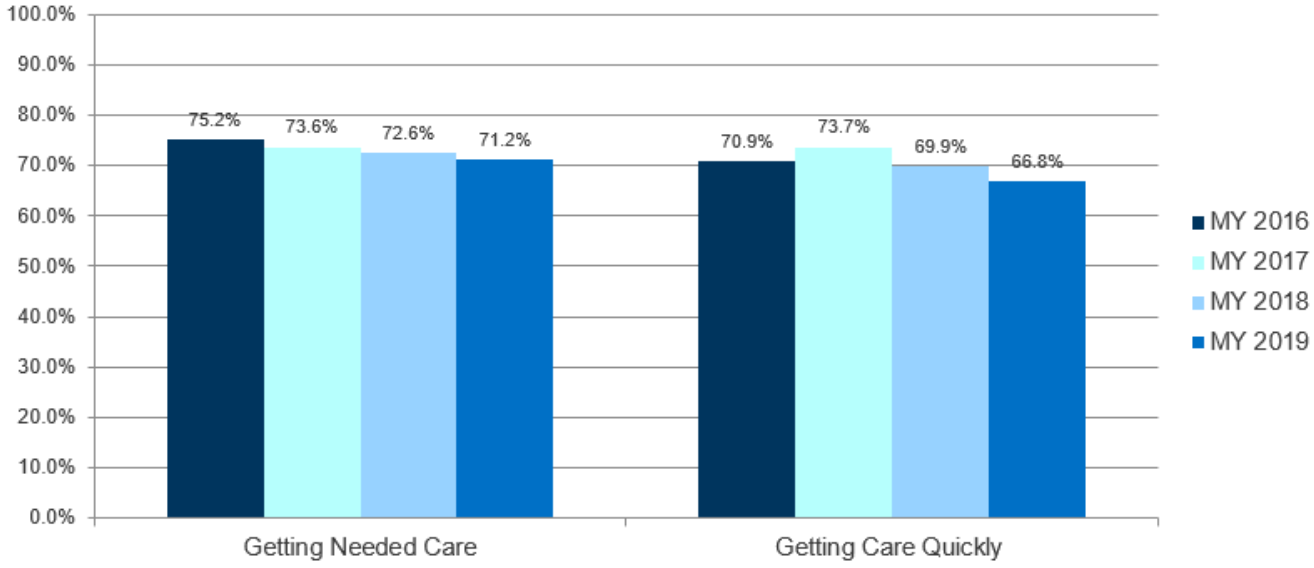
Red = less than 25th percentile

Back to Agenda

OC CAHPS Survey Results



OCC CAHPS Survey Results



In 2020, CalOptima reviewed all the CAHPS rates in detail and compared them to the benchmarks and found the access CAHPS measures, getting needed care and getting care quickly, to be high priority for the organization.

Access to Care

Timely Access Study

CalOptima monitors appointment availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities, and lower spending and better overall member satisfaction with health care. CalOptima fields a mystery shopper timely access survey to collect appointment wait times and compares them to standards from DHCS and CMS. A compliance rate is calculated by appointment type for each provider type.

In early 2020, the world was struck by the COVID-19 pandemic. In light of the COVID-19 pandemic, CalOptima placed a temporary hold on conducting the Timely Access Survey to ease the burden and allow network providers to focus operations on COVID-19. This decision to hold place a hold on the survey is aligned with DHCS' discussion to hold their timely access survey of the plans. Since a 2020 survey has not yet been fielded, CalOptima utilized results from the 2019 Timely Access Survey to evaluate access.

As part of this survey, the survey vendor made 6,981 total contact attempts. Of that only, 71.1% of the contact led to a live contact and only 26.2% led to an appointment time that can be compared to the benchmark. The survey vendor was not able to reach a large portion of the provider survey population.

Goal:
To meet internal goal of 80% for each individual measure and practitioner types

Of the 26.2% of the survey population across all LOBs where the vendor was able to obtain an appointment for comparison against the standards, the data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. All of the standards by provider type, with the exception of physician exams for PCPs and follow-up appointments for non-physician behavioral health, did not meet the internal goal at 80%. Rates were particularly low for urgent appointments and appointments with specialists. Based on the review of timely access study results, appointment access is an area of concern. When evaluating timely access for each of CalOptima's delegated HNs, the HNs similarly did not meet the internal goal of 80% for most of the standards.

Network Adequacy — Time and Distance Analysis
CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the plan meets the time and distance standards established by CMS and DHCS. In 2020, DHCS issued an updated All-Plan Letter on Network Certification and provided more guidance on the meeting the standards and on how to run the reports. Plans are now required to meet both time and distance standards where each zip code must have members meeting 100% access and plans also need to account for anticipated membership using a methodology pulling from the 2010 census. For all LOBs, the plan has met the time and distance standards with the exception of ENT/Otolaryngology and Orthopedic Surgery and in one zip code in south OC for Medi-Cal. For these zip codes not meeting the standards, we have requested for approval for an alternative access standard with DHCS at the plan level and are awaiting DHCS' response. When evaluating network adequacy for each of CalOptima's delegated HNs, the HNs did not meet all the time and distance standards. HNs had challenges providing geographic coverage for specialists, particularly in south OC.

Comparison to Complaints/Appeals
When the CAHPS results were compared to the Access grievances, CalOptima found that access grievances make up about 10% of all grievances in 2020. Compared to the previous year, the percentage of access-related grievances have maintained the same as last year. The top three sub-categories of access grievances are appointment availability, specialty care, and referral related access grievances. Of the access-related grievances, appointment availability continues to be a pain point for members with approximately 26% of all access-related grievances.

In early 2020, as the world was struck by the COVID-19 pandemic, CalOptima received more Customer Service calls and grievances related to the pandemic. To better address these member concerns, a COVID-19 Member Experience workgroup was formed to monitor, track and trend COVID-19 related issues. The workgroup reviewed COVID-19 related calls from Customer Service, grievances, potential quality issues (PQIs) and provider calls and feedback. The top calls were related to COVID-19 testing, general inquiries about COVID-19 and inquiries about their provider and benefits, including pharmacy benefits. The top COVID-19 related grievances were related to delay in care and COVID-19 testing. For delay in care grievances, members were concerned about providers not seeing patients, appointment delay or cancelled appointments during the pandemic. COVID-19 testing related grievances were related to PCP/office not referring or denying member for testing or that the provider did not know where to refer the member for testing.

Member Experience Activities Completed in 2020
The Member Experience Subcommittee identified access, member engagement and virtual care strategies as the areas of focus for 2020.

Virtual Care Initiatives
A virtual strategies workgroup was formed to implement virtual initiatives to improve access to care. The workgroup also worked to identify resources and staffing as well and guide request for proposals and contracting efforts with vendors. On May 7, 2020, CalOptima obtained Board approval for overall Virtual Care Strategy and Roadmap.

1. Member Texting: CalOptima secured Board approval for three years of funding and contracted with mPulse on 7/28/20 to provide one-way and two-way interactive texting campaigns to members. Interface testing is in progress and the first two campaigns to be implemented will be COVID-19 and flu shots utilizing one-way messaging. Although we were technically ready to go in October, the campaign is on hold pending DHCS approval to use texting to communicate with members.
2. PACE Telehealth Solution: CalOptima secured Board approval for funding to implement a technology platform using VSee to support PACE staff (clinicians) virtual visits with participants at home or other remote locations that will replace the use of Facetime/Google Duo during COVID-19 and support long-term need to engage participants at home. Pilot was started in October and rolled out to all PACE clinical teams by early December.
3. eConsult: CalOptima intends to implement a system that allows PCPs and specialists to securely share health information and discuss patient care that may replace the requirement for authorizations. A RFP has been issued and vendor selection is targeted for January 2021.
4. Behavioral Health (BH) Virtual Visits: CalOptima contracted with Bright Heart to provide BH virtual visits to our members. Bright Heart providers have been credentialed and visits began in August 2020. BH providers have been utilizing referrals for BH services, and member liaisons have been utilizing referrals for medication management services.
5. 24/7 eVisits: CalOptima intends to provide 24/7 direct access to physician virtual visits via website link or nurse advice line referral. CalOptima obtained Board approval for funding to issue an RFP by December with a target to contract with a vendor by March 2021.

A Member Experience Subcommittee was held in the beginning of 2020, and the committee determined that, in addition to the virtual strategies listed above, the committee would aim to implement the following initiatives:

1. CalOptima contracted with SullivanLuallin Group, a customer service improvement health care consultant, to continue to conduct provider shadow coaching and to hold workshops on customer service for office staff, office managers/supervisors and physicians to improve overall patient experience. When the COVID-19 pandemic struck in March 2020, CalOptima suspended all SullivanLuallin in-person training efforts to provider offices to be in compliance with the state-wide mandate to shelter-in-place. Mid-year, CalOptima decided to sunset this program and focus efforts on improving access to our members during the COVID-19 pandemic. The contract with SullivanLuallin will expire near the end of the year.
2. Approximately 15 providers were sent a notification letter in 2020 to address PCP member panel overcapacity with panel closures and member reassignment. In light of COVID-19, CalOptima suspended the notification letters and panel closures mid-year to ease the burden and allow network providers to focus operations on COVID-19. In 2020, 10 PCPs had their panels re-opened because they had met capacity for three consecutive months.
3. The member portal release three and four were implemented in 2020.
    - New forms and user interfaces for new registrations, login, forgot password, logout pages, were successfully deployed in March 2020.
        - Multiple security enhancements were completed in March 2020.
        - A new COVID-19 related message was added to the member portal's landing page reminding members about self-service options such as ordering ID cards, changing PCPs, checking eligibility and submitting inquiries to Customer Service.
        - New member registrations continue increasing steadily at an average rate of 600 new members per week.
        - A Customer Service member portal support team responds to questions about the portal, helps members navigate site functions and provides basic troubleshooting of access issues.
    - Additional language support for Spanish and Vietnamese was deployed on 5/30/20.
    - New member representative forms and registration wizards were deployed on 5/30/20.
    - Interpreter services requests were successfully deployed on 5/30/2020.
4. CalOptima authorizations have been extended from 90 to 180 days to allow members more time to utilize the authorization and see their provider. This extension was particularly vital during COVID-19, when providers may be rescheduling patients' appointments due to the pandemic.
5. In 2020, through continued analysis of auto authorization rules in the Cerecons portal, an additional nine specialties were identified as having 98%+ approval rate and auto authorization rules developed and implemented for initial consults effective April 1, 2020.

During the COVID-19 pandemic, CalOptima implemented the following initiatives to immediately address the members' needs during the pandemic:

1. CalOptima updated the website to bring forth COVID-19 related information including information on how to get tested, pharmacy benefits, telehealth options and how to obtain additional resources.
2. Updated the CalOptima website search function for COVID-19 to make the content easier to find.
3. Customer Service staff conducts member outreach calls with an average of 1,200 members per month to wish happy birthday and reminder to get physicals. Effective March 2020 COVID-19 scripting replaced the birthday call script to education members on social distancing and availability of resources and services offered by CalOptima and 211. Calls also inform members

of medical benefits during the pandemic with additional care options such as telehealth visits and nurse advice line.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time and Distance Analysis and complaints data, the general theme that stands out is that appointment access and delay in care is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2021, CalOptima will continue focusing on the key initiatives that were implemented in 2020 and develop additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers

Based on the CAHPS and member complaints data, CalOptima has identified that getting needed care and getting care quickly are the most critical measures, and therefore are the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

Access and Availability

1. Lack of extended office hours for appointments can be a significant barrier.
2. PCPs have too many members in their panel.
3. There may be an adequate number of practitioners in CalOptima's panel but not all providers have open panels or are available to see CalOptima new patients.
   - CalOptima is a delegated model and members are only able to see a provider in their HN.
   - A particular PCP and specialist group will not see members that are not in their system.
4. Certain geographic areas in OC, particularly south OC, do not have an adequate number of specialists for a particular type of specialty (i.e. pediatric subspecialties, oncologists, rheumatologists, etc.).
5. Not enough specialists are willing to contract with CalOptima.
   - Low reimbursement rates in comparison to other types of health insurance.

Provider Data Quality

1. Members not always able to get through to their provider to make an appointment.
   - Member calls reached voicemail, a closed office, an answering service or no answer at all
2. Members are referred to and approvals are sent to specialists who cannot see the patient.
   - Specialists/subspecialties/area focus is not clear, or information is not captured.
3. Open/close panel is not up-to-date
   - No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
4. System issue: FACETS shows no longer accepting patients, but Guiding Care shows as participating without any restrictions.

Prior Authorization Process

1. Timelines of submission of PCP and specialist in an issue. Provider office staff wait to submit the authorization request.

2. Providers do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometimes required and may cause delay in obtaining services.
3. Since UCI provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process which may make members feel like it takes a long time.

Opportunities for Member Experience in 2021

The Member Experience Subcommittee identified access to care as the areas of focus for 2021. CalOptima has established the goal of improving member experience for getting needed care and getting care quickly from 25th to 50th percentile.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

1. Implement the virtual care initiatives in the Virtual Care Strategy and Roadmap, including implementation of an eConsult system to serve as a peer-to-peer communication messaging platform between PCPs and specialists which will improve patient access to specialty care and overall quality of care.
2. Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
3. Monitor Time and Distance Standards by HN. While DHCS is requiring all plans to certify their delegated networks on network adequacy access performance by July 1, 2022, CalOptima will begin monitoring adequacy of network at the HNs level and developing implementation plans, as needed, in 2020 to ensure that each HN meets time and distance standards.
4. Member portal release five development scheduled for deployment at end of Q3-2020. Enhancements targeted include redesign of Change of PCP forms, improved filtering of Medical Groups on Provider Search results, update position of Medical Group Affiliations fields, and general enhancements to the dashboard.
5. Need to accelerate member portal adoption in 2021 provider outreach and education via a notification letter to providers not meeting the timely access standards. An escalation process has been developed to track continue instances of non-compliance that may lead to further action (i.e. corrective action plan, freezing panels, sanctions, etc.).

RECOMMENDATIONS FOR 2021

Based on the 2020 QI Program Evaluation we recommend the following initiatives and projects to drive improvement in quality outcomes that impact our members.

1. Continue member health rewards incentive program, specifically for preventive screenings such as BCS, CCS, COL, as well as other areas to impact measures like CDC, and PPC linked to Bright Steps. Work collaboratively with HNs to widen the promotion of these incentives. Utilize a third-party vendor to help reduce the intense staff resources required to process member incentives.
2. Intensify member outreach, by utilizing multiple modes of communications to reach members, either through website, direct mailings, IVR calls, and mobile texting. Leverage more electronic means versus resource intensive direct member outreach, as part of a more robust user-friendly communication/touchpoint plan.
3. Continue to utilize P4V measure set to drive improvement on MCAS measures plus additional access measures. Institute new BH P4V program in 2021 to help drive improvement in BH measures.
4. Prioritize data bridge efforts to improve data exchanges, both at the HN and plan level. In 2021 since many of the measures that were previously hybrid, are now administrative, it is imperative that data gaps continue to be identified and addressed. In addition, access to electronic medical record systems for contracted HNs, will help reduce the need for medical record review (and reduce provider abrasion) and will gain access to clinical care data elements not submitted via claims or encounter data. Seek to expand collection of lab data and results such as blood lead registry data and remind HNs of the opportunity to send point of care lab data via our electronic data submission process.
5. Expand virtual care strategies to increase access to care for members, such as BH Virtual care visits, e-visits, e-consults, PACE telehealth, and member texting platform (mPulse).

Based on the thorough 2020 QI Program Evaluation — in addition to continuing to advance CalOptima mission and improving quality outcome of our members — we recommend the implementing the 2021 Quality Improvement Goals in alignment with CalOptima's Strategic Priorities.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 25, 2021
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

4. Consider Recommending Board of Directors Approval of the CalOptima 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

Contacts

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Action

Recommend Board of Directors approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program (QI Program) and Quality Improvement Work Plan (QI Work Plan) must be reviewed, evaluated and approved annually by the Board of Directors.

The QI Program defines the structure within which QI activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detailed objectives, scope, timeline, monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year and reported to the QI Committee quarterly.

CalOptima staff has updated the 2021 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks, and strategic organizational changes. This will ensure that all regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

Discussion

The 2021 QI Program is based on the Board-approved 2020 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

The revisions are summarized as follows:

1. Updated signature page to reflect Interim Chief Medical Officer Emily Fonda, M.D., Quality Assurance Committee Chair Mary Giammona, M.D., and Board of Directors' Chair Andrew Do

Back to Agenda

2. Updated 2020 to 2021 dates throughout program, including up-to-date demographics on membership.

3. Updated Program Initiatives section to initiatives for 2021:
    a. Improve Health Equity and Mitigate Impact: COVID-19 Pandemic
    b. Whole Person Care
    c. Health Homes Program
    d. Homeless Health Initiative
    e. Pharmacy Administration Changes
    f. Virtual Care Strategy

4. Updated Role of CalOptima Officers for QI Program to reflect current organizational roles and responsibilities.

5. Updated 2021 QI Goals and Objectives:
    a. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during the COVID-19 pandemic.
    b. Improve member access to care by 10% from 2019 baseline.
    c. Achieve Accredited NCQA status post 2021 Health Plan Renewal Survey and maintain overall rating at 4.0.

6. Updated language in the Facility Site Review and Medical Record sections to reflect current regulatory descriptions.

7. Moved language related to the description of QI projects standards and documentation from Quality Analytics section to the Population Health Management section.

8. Updated 2021 Delegation Grid to reflect delegated activities consistent with 2020 NCQA Standards, and regulatory requirements.

The recommended changes are designed to better review, analyze, implement and evaluate components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2021 QI Program and QI Work Plan does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Proposed 2021 Quality Improvement Program and Work Plan (Redline version)
2. Proposed 2021 Quality Improvement Program and Work Plan (Clean version)
3. PowerPoint Presentation: 2021 Quality Improvement Program and Work Plan

/s/ Richard Sanchez *02/17/2021*
Authorized Signature **Date**

Back to Agenda

~~Reviewed by MKC 12-03-20~~

~~2020~~2021

QUALITY IMPROVEMENT PROGRAM

~~2020~~ 2021 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

_____

~~David~~ Emily Fonda~~Ramirez~~, M.D. _____ **Date**
Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

_____

~~Paul Yost~~Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

_____

Back to Agenda Back to Item

~~Paul Yost~~~~Mary Giammona~~Andrew Do~~, M.D.~~

Date

TABLE OF CONTENTS

Back to Agenda Back to Item

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members ~~is~~ was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration~~:~~

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability~~:~~

We were created by the community, for the community, and are accountable to the community. The following ~~Meetings~~ meetings are open to the public ~~are~~: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect~~:~~

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.

- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (~~OC~~ HCA).
- Substance use disorder services are administered by ~~OC~~ HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including ~~Orange County Health Care Agency (OC~~ HCA~~)~~ and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare ~~benefits~~, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated

services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare ~~benefits~~. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits, and transportation. OCC also includes personalized services through the PCCs to ensure ~~each~~ members receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

Program Initiatives

Mitigate Impact and Improve Health Equity: ~~from~~ COVID-19 Pandemic[SG1][OE2]

The COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE, and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, ~~as well as~~and the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. -Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. -The COVID-19 pandemic shined a ~~blazing~~ bright light on the health disparities and inequity. -The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths~~,~~ but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima ~~has~~ identified opportunities to improve health equity as laid out in its~~the~~ QI ~~w~~Work ~~p~~Plan. -Additionally, the COVID-19 pandemic adversely impacted the mental health of ~~all~~[CM3]-many members, especially ~~for~~ children. -Hence, several trauma-informed interventions ~~will be~~are included in the 2021 QI ~~w~~Work ~~p~~Plan to address the toxic stress and Adverse Childhood Experiences (ACEs~~S~~) related to the COVID-19 pandemic.~~Intervention Team (ACE IT) was developed to provide members who screen positive or at moderate risk level for ACEs access to supportive services, with the goal to help members develop resiliency and minimize negative impact of ACEs on health outcomes.~~

~~Whole-Person Care~~Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017~~–~~2019 Strategic Plan. In Orange County, the pilot is being led by the ~~OC~~ HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. ~~For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.~~ However, WPC ~~is~~was scheduled to terminate on December 31, 2020~~,~~; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition

was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity, rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program, and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implemented HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During the implementation, of HHP,

CalOptima's goal is to targeted the highest risk 3–5% percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing--related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.CalOptima has partnered with the OC HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers that they have been working with for their housing--related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connrrections[SG4][OE5]; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole--Person Care program, recuperative care services provide post-acute care for up to 90- days for homeless CalOptima members:. OC HCA and CalOptima split the cost of recuperative care on a 50/50 basis;. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to OC HCA in connection with the Whole--Person Care program, and the CalOptima Board of Director's has authorizationed tothe extendsion of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.-
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to OC HCA to provides additional respite care beyond the 90 days of recuperative care under the Whole--Person Care program.- These grant funds have been exhausted.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency'sHCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in -person.
-
- Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventative care services and care coordination helps connect the member back to the primary care delivery system.- Community health centers work with nearby shelters and hot spots that meet the program requirements and will receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we will beare able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima will have be able to provides preventive screenings, and chronic care, care coordination, and follow- up.

- ~~The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.~~

- Hospital Discharge Process for Members Experiencing Homelessness—~~-~~Support is provided to assist hospitals with the increased cost associated with discharge planning under ~~new~~ state requirements.

Pharmacy Administration Changes

It is expected that, e~~E~~ffective April 1, 2021, the Department of Health Care Service (DHCS) ~~is~~will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing,~~/~~/ prior authorizations, formulary administration, and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima--retained responsibilities will include physician-administered drug claims processing~~/~~, prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board.– This change is for the Medi-Cal program only, and does not affect the ~~OC/OCC~~OneCare/OneCare Connect, and PACE [SG6][OE7]~~programs~~ lines of business.

Virtual Care Strategy

In 2020~~1~~, ~~the~~ federal and state rules and regulations provided~~ing~~ limited waivers for telehealth due to the COVID-19 pandemic~~,~~ that enabled CalOptima to accelerate its virtual care strategy under COVID-19 shelter--at--home measures. -Members were able to receive appropriate health care services though telephone and video visits. CalOptima plans to continue expanding implementation of various ~~V~~virtual ~~C~~care s~~S~~trategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management~~;~~.

2. Leverage existing delivery model where possible~~;~~.

3. Be proactive in seeking out opportunities to innovate.~~; and~~

4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work ~~p~~Plan. With these ~~V~~virtual ~~C~~care ~~S~~strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. ~~1)~~ Improved member access and convenience.

2. ~~; 2)~~ Reduced avoidable in-person visits to specialists.~~; and 3)~~
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as: ~~I~~improved member experience~~;~~, ~~A~~augmented network capacity and adequacy~~;~~, and ~~I~~improved clinical quality outcomes.

~~*Behavioral Health for OC/OCC*~~

~~CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1,2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.~~

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima ~~H~~health n~~N~~etwork (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. ~~Members enrolled in CalOptima Direct-Administrative are not HN- eligible.~~

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. – CCN is administered directly ~~internally~~ by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for ~~growth~~access.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)

- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following ~~13 Hheath Nnetworks~~HNs[SG8][OE9]:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	~~SRG~~	~~SRG~~
Family Choice Medical Group		SRG	SRG
~~Heritage~~ HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch ~~Family~~ HealthCare	~~HMO~~	SRG	~~HMO~~
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan~~Medical Group~~	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management ~~(UM)~~
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer S~~s~~ervice~~s~~ activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

[OE10]

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

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

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the ~~Centers for Medicare & Medicaid Services (~~CMS~~)~~ Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program—and in collaboration with its providers and community partners—CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA and meet DHCS/CMS quality ~~requirements~~ and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- ~~Sets~~ Setting expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes.~~.~~
- ~~Supports~~ Supporting the provision of a consistent level of high quality ~~of~~ care and service for members throughout the contracted provider networks, as well as ~~monitors~~ monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers.~~.~~
- ~~Provides~~ Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

  ~~Ensures~~ Ensuring certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority ~~OC~~ HCA which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.~~, as reported by the HNs~~[SG11]~~.~~
- ~~Promotes~~ Promoting patient safety and ~~minimizes~~ minimizing risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and ~~works~~ working with appropriate committees, departments, staff, practitioners, provider medical groups~~,~~ and other related O~~o~~rganizational P~~p~~roviders (~~OPS~~OPs) to assure that steps are taken to resolve and prevent recurrences.
- ~~Educates~~ Educating the workforce and ~~promotes~~ promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes ~~apply to populations served~~are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD-A network providers serving CalOptima's various populations~~, to~~:

- Support~~ing~~ the agency's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently~~.~~
- ~~The c~~Continuously improve~~ingment of~~ clinical care and service~~s~~ quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population~~.~~

- ~~The t~~Timely identifying ~~ication of~~ important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high- risks, and disease profiles for both acute and chronic illnesses, and preventive care~~.~~
- ~~The~~ Ensuring continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities~~.~~
- ~~The~~ Ensuring accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population~~.~~
- ~~The~~ Monitoring the qualifications and practice patterns of all individual providers in the network to deliver quality care and service~~.~~
- ~~The~~ Promoting the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances~~.~~
- ~~The~~ Ensuring the reliability of risk prevention and risk management processes~~.~~
- ~~The~~ Ensuring compliance with regulatory agencies and accreditation standards~~.~~
- ~~The accountability cadence of~~Ensuring the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans~~.~~
- ~~The~~ Promoting the effectiveness and efficiency of internal operations~~.~~
- ~~The~~ Ensuring the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs~~.~~
- ~~The~~ Ensuring the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values~~.~~
- ~~The~~ Ensuring compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES~~,~~ AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's s~~S~~tate and f~~F~~ederal ~~C~~contracts — and to CalOptima's Chief Executive Officer (CEO), as ~~discussed~~ described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify ~~the~~ member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with ~~F~~federal and ~~S~~state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and ~~review and~~ make recommendations to the Board regarding ~~accepting~~ the overall QI Program. QAC ~~and annual evaluation, and~~ routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives~~,~~ and ~~improvements~~quality performance results achieved. The QAC also makes recommendations to the Board for ~~for~~ annual approval with modifications and appropriate resources allocations of the QI Program ~~and actions~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim~~, moving upstream from the~~(which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation~~,~~ and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preven~~ta~~tative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons ~~—~~ ~~M~~medical ~~S~~safety ~~N~~net
- ~~OC HCA~~
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs ~~—~~ ~~B~~behavioral/~~M~~mental ~~H~~health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by ~~OC~~ HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and ~~C~~c~~C~~ommunity-~~B~~b~~B~~ased ~~S~~s~~S~~ervices [SG12](HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
  - HCA, Behavioral Health
  - OC SSA
  - OC Community Resources Agency, Office on Aging
  - ~~OC HCA, Behavioral Health~~
  - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent ~~a~~ the broad provider community that serves CalOptima members. The PAC ~~is comprised of~~has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of ~~OC~~ HCA, which maintains a standing seat. PAC meets at least quarterly and ~~are~~ is open to the public. The 15 seats include:

- ~~HN~~ Health networks
- Hospitals
- Physicians (three ~~3~~ seats)
- Nurse
- Allied health services (~~2~~two seats)
- Community health centers
- ~~OC~~ HCA (~~1~~one standing seat)
- LTSS (LTC facilities and CBAS) (~~2~~ ~~1~~one seat~~s~~)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

~~In 2018, CalOptima's Board of Directors established the~~ Whole-Child Model Family Advisory Committee (WCM FAC), ~~a~~~~is~~has been required by the state as part of California Children's Services (CCS) ~~when~~since it bec~~o~~am~~e~~~~ing~~ a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: ~~7 9~~seven to nine seats

    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are ~~a~~ current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
    - ~~o~~
- Interests of children representatives: ~~2 to~~ 4two to four seats
    - Community-based organizations; or
    - Consumer advocates

Members of the c~~C~~ommittee shall serve staggered two-year terms. ~~Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term.~~ WCM FAC meets at least quarterly and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the s~~S~~tate and f~~F~~ederal ~~Contracts~~contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) —oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met.– The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care practitioner in the QI program who~~, and~~ serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC.~~–~~ The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED ~~of~~ Q&PHM) is responsible for facilitating the company~~-~~wide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED ~~of~~ Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED ~~of~~, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED ~~of~~ Q&PHM are the~~:~~ Directors of~~,~~ Quality Analytics~~,~~; ~~Director,~~[CM13] Quality Improvement~~;~~, ~~Director,~~ Population Health Management~~;~~, ~~Director,~~ Behavioral Health Services (Clinical Operations)~~;~~ and ~~Director,~~ Behavioral Health Integration.

Executive Director, Clinical Operations (ED ~~of~~ CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including~~:~~ UM, Care Coordination, Complex Case Management, LTSS and MSSP ~~S~~services, along with new program implementation related to initiatives in these areas. The ED ~~of~~ CO serves as a member of the executive team~~,~~ and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED ~~of~~ PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED ~~of~~ PI are the directors of both Process Excellence and ~~: Director, Process Excellence; and Director,~~ Strategic Development.

Executive Director, Compliance (ED ~~of~~ C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs~~,~~ and other functional areas. The ED ~~of~~ C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED ~~of~~ C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to s~~S~~tate and ~~F~~federal requirements.

Executive Director, Network Operations (ED ~~of~~ NO) leads and directs the integrated operations of the HNs~~,~~ and must coordinate organizational efforts internally~~, as well as~~ and externally~~,~~ with members, providers and community stakeholders. The ED ~~of~~ NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED ~~of~~ O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, ~~Government~~ Public Affairs (Chief of Staff) ~~(New)~~ is responsible for the oversight and measurement of CalOptima's communications, legislative, community relations~~,~~ and strategic development programs.~~ –~~ The ~~eChief of Sstaff~~ED ~~of~~ PA ~~will~~ assists the CEO in carrying out organizational goals~~,~~ and ~~will~~ planning, developing and implementing strategies to effectively communicate and implement the CalOptima mission with internal and external contacts, including employees, the public, members, providers, government officials, and the media.

~~Add JD~~

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, t~~T~~he QIC oversees ~~in collaboration with the Compliance Committee~~ the performance of delegated functions ~~by monitoring~~by monitoring its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes ~~a~~ participating practitioners ~~that~~who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed~~,~~ and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include ~~the following~~:

- ~~Recommends~~ Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- ~~Oversees~~ Overseeing the analysis and evaluation of QI activities.
- ~~Makes~~ Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation, and review of QI program activities.

- ~~Identifies~~ Identifying and ~~prioritizes~~ prioritizing needed actions and interventions to improve quality.
- ~~Makes~~ Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners, and delegated health networks are evaluated, such as UM over/under utilization in collaboration with ~~ABA~~applied behavioral analysis utilization, and recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with ~~4~~ four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data ~~and~~ collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter~~,~~ and includes, but may not be limited to~~, the following~~:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration

- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year~~,~~ and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code §-14087.58(b), Health and Safety Code §-1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the c~~C~~ommittee ~~C~~chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of W~~w~~ork ~~p~~Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process,~~;~~ and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates, and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues

and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate~~,~~ and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its ~~program~~ lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-~~011~~023. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations, and referrals for the "pain points" in health care that impact our members. In 202~~0~~1, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least ~~bi-monthly~~quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2021~~0~~ and MY 2022~~1~~ CAHPS survey results.

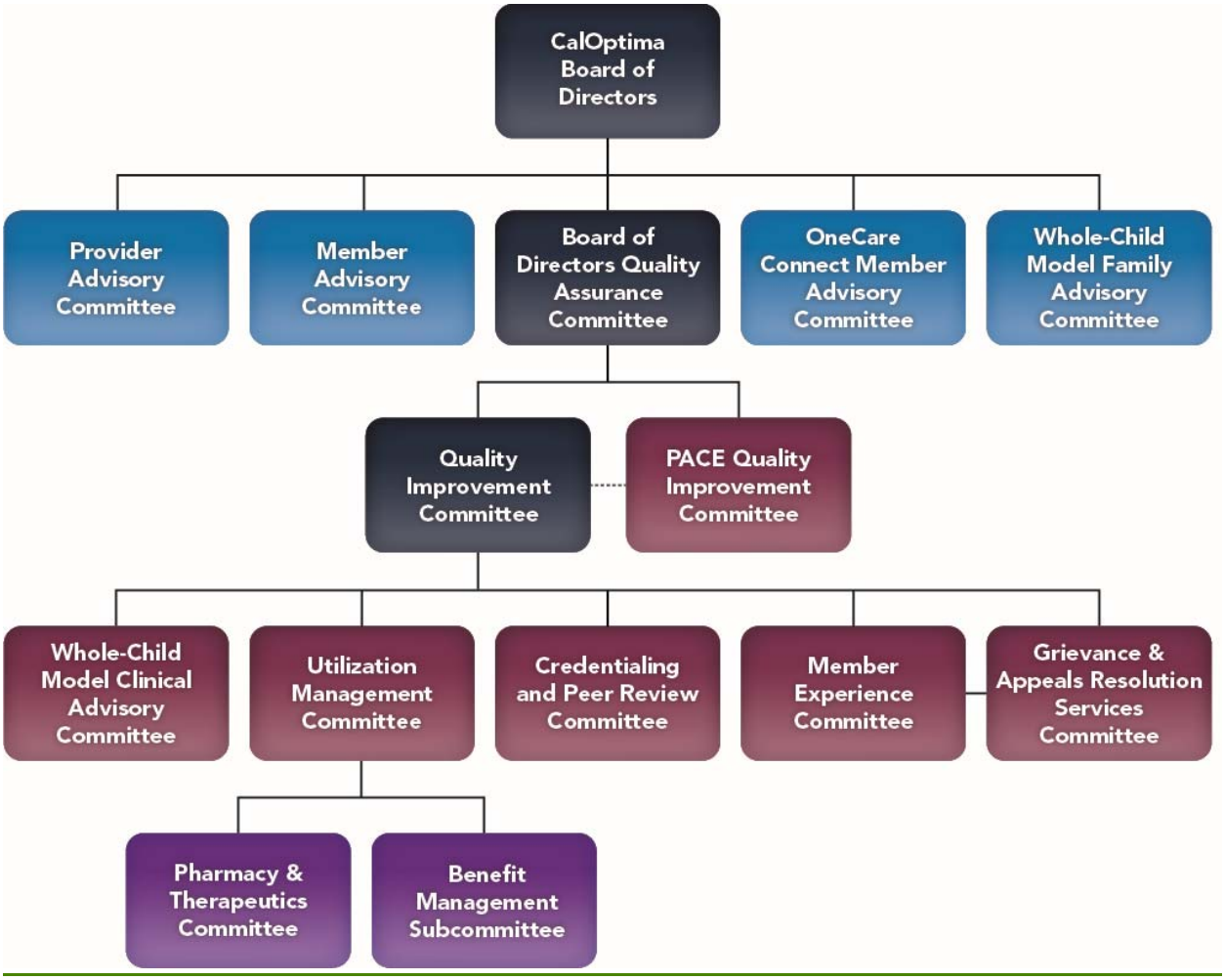
Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

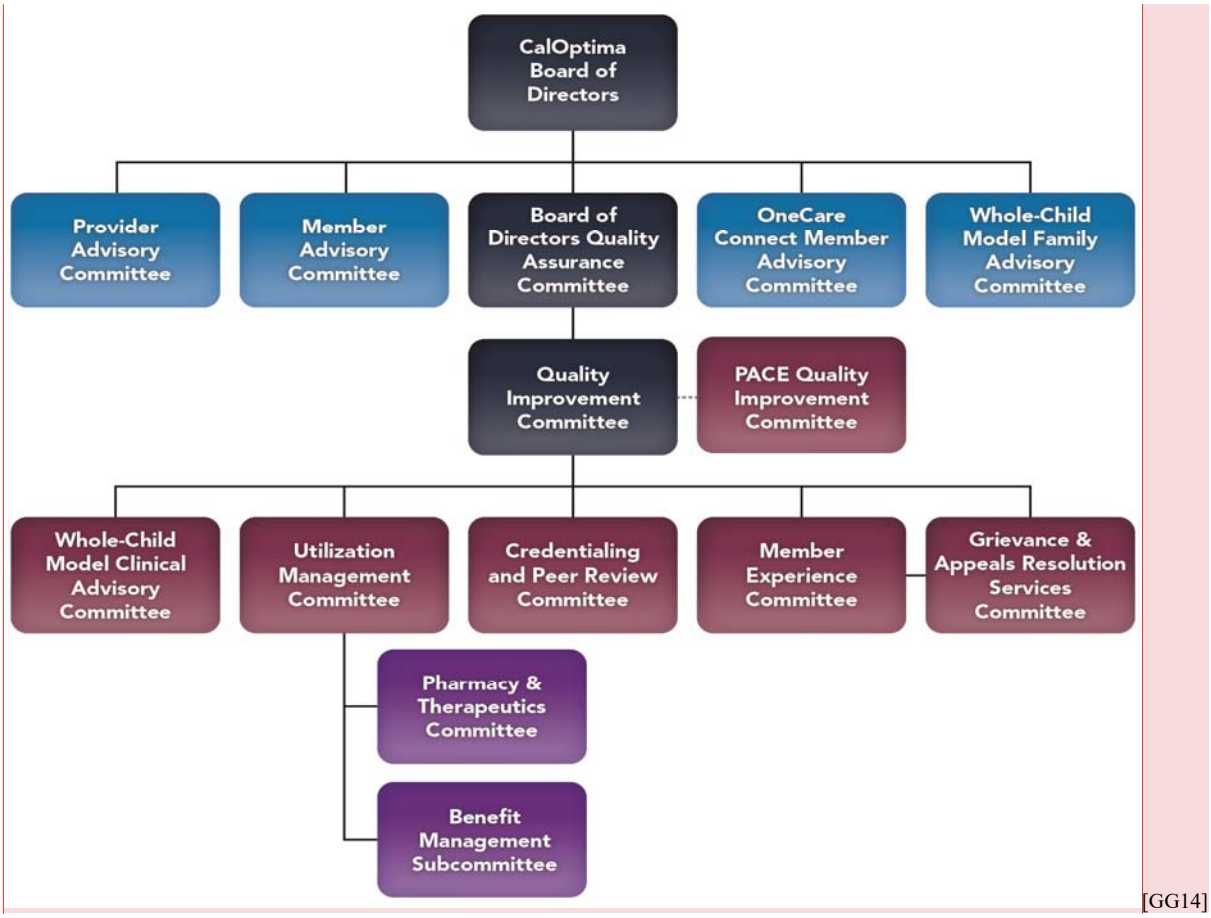
Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)

The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

~~2020~~ Committee Organization Structure — Diagram



Back to Agenda Back to Item



[GG14]

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees—including contracted professionals who have access to confidential or member information—sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

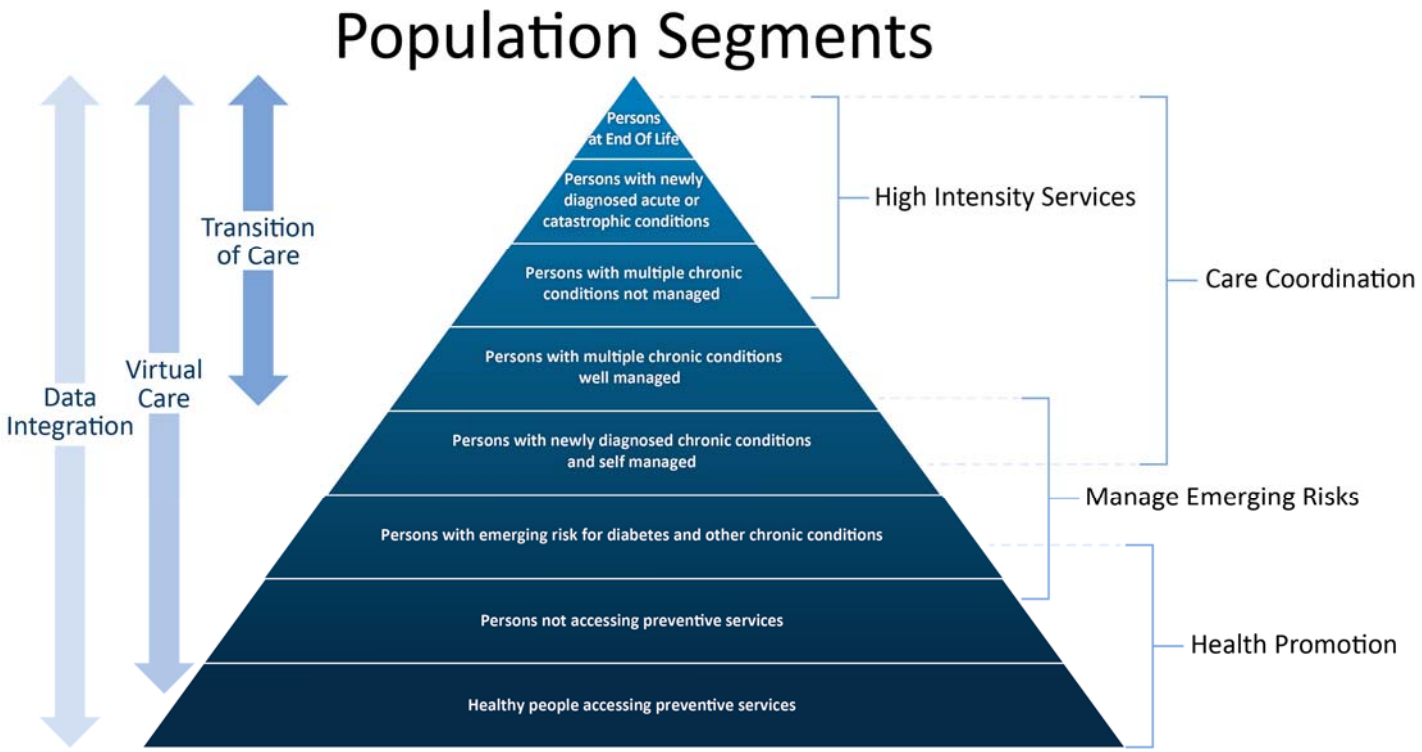
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure ~~supports~~ provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by~~,~~ stratifying the~~our~~ population based on their health needs, conditions, and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2021~~0~~ QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



Back to Agenda Back to Item

CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one- by- one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

20210 QI Goals and Objectives[SG15][OE16]

CalOptima's QI Goals and objectives are aligned with CalOptima's 20210–20221 Strategic goals.

1. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.

2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.

1.3. Achieve Accredited NCQA status post 2021 Renewal Survey, and mMaitainMaintain Increase NCQA overall rating from at 4.0 to 4.5
Improve

These top three priority goals were chosen to be aligned with CalOptima's strategic objectives related to the pandemic, as well as continued goals related to access to care and NCQA Accreditation. The 2021 QI Workplan details the planned activities to meet the COVID-19 vaccine aim which include an immunization strategy, a targeted communication strategy and a member incentive strategy. The planned activities related to member's ability to access care are captured in the Virtual Care strategy as well as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). Finally, the goal of achieving NCQA---Accredited status in 2021 and maintaining the overall health plan rating is a high priority since CalOptima will be pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

1. Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly
1. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

Detailed strategies for achieving 2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima ~~the~~ strategic priorities and the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the s~~S~~tate or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities

- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual patient care ~~to aid~~aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2021 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2021~~0~~ QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.
- Measures required by regulators, such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement~~,~~ and ~~is occurring~~occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority~~, which~~ that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance~~,~~ (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, ~~M~~management, QIC, UMC, etc., based upon the scope of work and impact of the effort.
- These improvement efforts are often cross~~-~~-functional~~,~~ and require dedicated resources to assist in data collection, analysis~~,~~ and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality M~~m~~easures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers~~,~~ or predictors of the desired outcome measures or lag quality measure, such as HEDIS and ~~STARS~~ Stars measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN~~s~~, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. ~~See explanation of Clinical Data Warehouse below.[SG17]~~

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with ~~5–10~~5–10% ~~percent~~ over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411~~,~~ and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% ~~percent~~ of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depend~~ent~~ing on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI ~~w~~Work ~~p~~Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors,– through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forums, and other ongoing ad -hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both web-site and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes, and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on ~~the our~~CalOptima's website, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation, and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED, ~~of~~ Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED ~~of~~, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - QI Nurse Specialists
  - Program Policy Analyst
  - Credentialing Coordinators
  - Program Specialists (including Intermediate and Senior)
  - Program Assistants
  - Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics Network Adequacy Manager
  - Quality Analytics Data Analytics Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management

Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dietietians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health Integration
pProvides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration Ddepartment efforts in integrated care, quality initiatives, and community partnerships. The Ddirector ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operations)
pProvides clinical operational oversight and leadership to the implementation, expansion, and/or improvement of processes and services s of the Behavioral Health Integration dDepartment clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and ~~utilization management~~UM for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management
A assists in the development and implementation of the UM program, policies, and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective, and retrospective reviews that support UM medical management decisions, serves

on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management
~~l~~Leads the development and implementation of the Pharmacy Management (PM) program, develops, and implements PM department policies and procedures,~~;~~ ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of ~~P~~pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics ~~c~~Committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
R~~is r~~esponsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports
~~is r~~Responsible for LTSS programs, which include CBAS, LTC~~,~~ and MSSP. The position supports a ~~"Member Centric"~~member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures~~,~~ and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics
~~p~~Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and ~~roadmap~~road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the ~~roadmap~~road map. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the ~~e~~Enterprise ~~a~~Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job-~~-~~specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)

- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training
- ~~QI Lean training curriculum (added to CalOptima University in 2019)~~

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization, and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC~~,~~ and QAC~~,~~ and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.

- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors' review and approval.

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care, and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM and CM Programs and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight

- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

** CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities.
  - Drive improvement of quality of care received.
  - Minimize rework and unnecessary costs.
  - Measure the member experience of accessing and getting needed care.
  - Empower staff to be more effective.
  - Coordinate and communicate organizational information, both division and department-specific, as well as agency-wide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agency-wide practices that support accreditation and meeting regulatory requirements.

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to

CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following:, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to:, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and delegated to HNs and other sub-delegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and re-credentialing of organizational providers (OPs) such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with sState and Ffederal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Ffederal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care ~~practitioner~~ provider (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR, and physical accessibility review survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% ~~percent~~ on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with MMCD Policy Letter 14-004 and CalOptima policies. The Initial Medical Record Review shall be completed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR, and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.
~~Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full-scope site review performed by another health plan in the past three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.~~

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room

- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that its contracted delegated HNs make certain that each member's~~'~~ medical record is maintained in an accurate manner that is current, detailed, organized and easily accessible to treating practitioners. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.~~–~~ All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care~~,~~ in such a way that it facilitates communication, coordination and~~,~~ continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by ~~S~~state and ~~F~~federal laws and regulations, and the requirements of CalOptima's contracts with CMS~~,~~ and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable ~~F~~federal and ~~S~~state law.

~~**CalOptima requires that its contracted delegated HNs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.**~~

~~The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, and DHCS.~~

~~The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.~~

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the ~~appropriate~~ relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance

Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.
- ~~Identification and reporting of medical disciplinary cause or reason issues to the appropriate state board.~~[SG18]
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- ~~Prescribed continuing education or office training~~
- ~~De-delegation~~
- ~~De-credentialing~~
- ~~Contract termination~~[SG19][OE20]

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.

- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider--specific performance on quality metrics, as required.
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners.
- Facilitate satisfaction surveys for members. and[CV21] practitioners.
- Provide agency-wide oversight of monitoring activities that are:
  - Balanced: Measures clinical quality of care and customer service
  - Comprehensive: Monitors all aspects of the delivery system
  - Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case mManagement reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data, and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARStars and HOS measures. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping mMembers Hhealthy
2. Managing Mmembers with eEmerging rRisks
3. Patient Ssafety or Ooutcomes Aacross Ssettings
4. Managing Mmultiple Cchronic Cconditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, andwhich was adopted again in 2020. The 2019 PHM Strategy will continue into 2021,0 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&Lcultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct Qquality Iinitiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. QQuality Iinitiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 20210 are tracked in the QI Work Pplan and reported to the QIC.

In 20210, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services, and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions.

Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member--focused trauma informed care to be consistent with NCQA ~~2020~~ Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma--Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The ~~population health management~~PHM team also focuses on improvement projects such as QIP's, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

~~Interventions~~

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member--specific interventions, such as reminder notices and informational communication, are developed and implemented.

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Documentation of QI Projects

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- 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.
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- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agency-wide ~~population health~~ PHM programs**.** PHM programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members, and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management, ~~and~~ Tobacco Cessation, Asthma, Immunizations, and Well Child Visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources, and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, ~~that~~which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner, and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of social determinates of health (SDOH). It proactively identifies those members in need of closer management, coordination, and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC, and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination, and basic are specific to SPD, OCC, and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP

        - Communication with members or their representatives, vendors, and medical group
        - Review and update the ICP at least annually, and when there is a change in the member's health status
        - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - ~~Meets~~ Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization

- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and ~~at~~ at high-risk individuals
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy,

psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated~~,~~ to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including ~~utilization management~~UM, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC

~~CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1~~In~~,~~ 202~~1~~0, OC/OCC behavioral health ~~will~~ continues to be ~~be~~ fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician, or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2021~~0~~ UM Program Description. ~~and related Work Plan.~~

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and ~~roadmap~~road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved, and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture, and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results~~;~~, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings, including CBAS, SNF, and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, critical incident identification, appropriate investigation, and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 Infection Prevention and Protective Equipment
  - MRSA prevention program (Shield)
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact~~;~~, 24-hour access to telephonic interpreter services~~;~~, member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, ~~PDF~~ or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- OC member materials are provided in three languages: English, Spanish and Vietnamese.
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services

- QI program for all lines of business~~,~~ (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards).
- Behavioral Health for MC, OC, and OCC lines of business
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, and peer review process on specific, referred cases
- Development of system-wide measures, thresholds, and standards
- Satisfaction surveys of members, practitioners, and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and ~~health care delivery~~ organizational providers (OPs)~~rganizations OP~~[SG22][OE23]
- Credentialing and re-credentialing of OPs~~of OPs~~[SG24]
- Development of UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2021~~0~~ Delegation Grid.

See Appendix B — 2021~~0~~ Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

Appendix A — 2021~~0~~ QI Work Plan

APPENDIX B — 2021~~0~~ DELEGATION GRID

APPENDIX C — ~~QI~~ ORGANIZATIONAL CHART

2021 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2021 QI Annual Oversight of Program and Work Plan
B. 2020 QI Program Evaluation
C. 2021 UM Program
D. 2020 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program updates (Health Network Quality Rating, MCAS, P4V)
M. Improvement Projects (All LOB)
QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC
N. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
O. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
P. Homeless Health Initiatives (HHI): Health Homes Program Phase 2
Q. Health Equity

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted to Board of Director's: Date:

Quality Improvement Committee Chairperson:

Emily Fonda, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, MD Date:

B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
C. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*, which is a NCQA Accreditation Measure

D. Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations
B. Blood Lead Screening

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Virtual Care Strategies

VIII. QUALITY OF SERVICE- Member Engagement

A. Improve Member Experience- Member Engagement

IX. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure.
   OCC Quality Withhold measure.
B. Quality of Care Grievances and Potential Quality Issue
   (GARS/PQI) Processing
C. Post-Acute Infection Prevention Quality Incentive (PIPQI)
D. Orange County COVID Nursing Home Prevention Program.

E. LTC Facility Transfer Plan due to COVID-19

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT								
2021 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2021 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by February 2021	Betsy Ha				
2020 QI Program Evaluation	Complete Evaluation 2020 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by February 2021	Betsy Ha				
2021 UM Program	Obtain Board Approval of 2021 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by February 2021	Mike Shook				
2020 UM Program Evaluation	Complete Evaluation of 2020 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by February 2021	Mike Shook				
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Pshyra Jones				
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima				
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Ana Aranda				
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook				
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD				
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital				
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V). Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital				
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures- Due March 2nd. **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo/Cathy Osborn				
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achive program milestones quarterly and annual performance goals	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Quarterly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Quarterly Adoption of Report	Edwin Poon				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Sloane Petrillo				
Homeless Health Initiatives (HHI): Health Homes Program Phase 2	Improve Health & Access to care for enrolled members	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI 5. Focus on telephonic outreach d/t COVID-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Quarterly Report	Sloane Petrillo				
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Pshyra Jones/Betsy Ha/Marie Jennis				
II. QUALITY OF CLINICAL CARE- Adult Wellness								
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	**MY2020 Goal:** **CCS -** MC 60.65% **COL** - OCC 73%, OC 62% **BCS** -MC 58.67%, OCC - 76%, OC - 76%	1) Continue $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Track the number of mammograms scheduled through targeted outreach. 4) Member Health Rewards RFP and Vendor Contract	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (16 and over).	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a.They are now eligible to be vaccinated. b.Where they need to go to be vaccinated (when available) c.This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health								
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2020 Goal:** 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:18.20 %	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	12/31/2021	Edwin Poon	Yes			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**MY2020 Goal:** MC - Init Phase - 43.41% MC -Cont Phase - 55.05%	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	12/31/2021	Edwin Poon	Yes			
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS MY2020 Goal:** **MC:NA**	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	12/31/2021	Edwin Poon	Yes			
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 41% OC 56% OCC 56%	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	12/31/2021	Edwin Poon	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE- Chronic Conditions								
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**HEDIS MY2020 Goal: (A1C Poor Control)** MC:37.47% OC: 19.46% OCC: 19.46%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Member Health Rewards RFP and Vendor Contract 3) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS MY2020 Goal: (Diabetric Eye Exams)** MC: 58% OC: 67.5% OCC: 67.5%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
V. QUALITY OF CLINICAL CARE- Maternal Child Health								
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	**HEDIS MY2020 Goal:** Prenatal 83% Postpartum 65%	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	12/31/2021	Ann Mino	Yes			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness								
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	**HEDIS MY2020 Goal:** MC 68.37%	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Blood Lead Screening	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2020 Goal**: Lead Screening 50th percentile 73.11%	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials, 4) Prop 56 provider value based payments for Blood Lead Screening	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access								
Improve Access: Reducing gaps in provider network	Contract with a minimum of 25% of targeted providers identified by the network adequacy work group.	1) Actively recruit hard to access specialties for CCN	12/31/2021	Michelle Laughlin/Jennifer Bamberg				
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists by 10 percentage points.	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After All Attempts** from 28.3% to 25.0%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Virtual Care Strategies	Increase telehealth utilization rate from 24.1% to 30% (visit count/# members) Increase member telehealth usage from 8.8% to 10% (teleheatlh member count/# members)	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	12/31/2021	Marsha Choo/Rick Cabral				
VIII. QUALITY OF SERVICE- Member Engagement								
Improve Member Experience: Member Engagement	Increase member engagement via member portal.	1) Member Portal 2) Member Outreach Calls	12/31/2021	Mauricio Flores/Andrew Tse				
IX. SAFETY OF CLINICAL CARE								
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2020 Goal**: MC - NA OC 8%;OCC 0.85 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	12/31/2021	Mike Shook	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	Provide clinical recommendations to members with a quality of care grievance within 30 days.	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	12/31/2021	Laura Guest/Ana Aranda				
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2021	Cathy Osborn/Scott Robinson	Yes			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COVID-19 as soon as possible 2) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COVID 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www.ucihealth.org/stopcovid	5/31/2021	Cathy Osborn/Scott Robinson				
LTC Facility Transfer Plan due to COVID-19	Transfer 100% of CalOptima members to other facilities within 5 days of evacuation notice.	1) Train all LTSS staff in LTC operational DTP: LTC015 LTC facilities planned and unplanned closure process. 2) Monitor all nursing facilities for COVID_19 positive rates in members and facility staff 3) Identify high-risk facilities that hae COVID-19 related staffing shortages and high infection rates that my require evacuation. 4) Identify and maintain a log of available nursing facility beds that members could be transferred to.	12/31/2021	Scott Robinson				

APPENDIX B — 2021 DELEGATION GRID

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.2.4	PHM2D: Segmentation-PHM	X		X	
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X		X	
3.4.2	NET4B: Continued Access to Practitioners	X		X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA for Interim Surveys only
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				NA for Medicaid
4.9.6	UM9F: Appeals Overturned by the IRO				NA for Medicaid
4.9.7	Provider Appeals Provider Complaint Processing	X	X	X	
4.10.1	UM10A: Written Process				NA for Medicaid
4.10.2	UM10B: Description of the evaluation Process				NA for Medicaid
4.11.1	UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X	
4.11.2	UM11B: Pharmaceutical Restrictions/Preferences	X		X	
4.11.3	UM11C: Pharmaceutical Patient Safety Issues	X		X	
4.11.4	UM11D: Reviewing and Updating Procedures	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.11.5	UM11E: Considering Exceptions	X		X	
4.12.1	UM12A: UM Denial System Controls	X	X	X	
4.12.2	UM12B: UM Appeal System Controls	X		X	
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				NA due to Carve out
5.7.4	CR7D: Assessing Medical Providers	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.5	CR7E: Assessing Medical Providers				NA due to Carve out
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations				NA for Medicaid
6.3.2	ME3B: Communication with Prospective Members				NA for Medicaid
6.3.3	ME3C: Assessing Member Understanding				NA for Medicaid
6.4.1	ME4A: Functionality: Website	X		X	Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X		X	Not Required for Renewal Survey

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			May not be Delegated
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Claims Processing Timeliness of Claims and Interest on Late Claims	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR)	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
7.1.7	Third Party Liability (TPL) CalOptima policy FF.2007: Reporting of Potential Third-Party Liability.	X	X	X	
7.1.8	Family Planning Services CalOptima Policy GG.1118: Family Planning Services, Out-of-Network	X	X	X	

Note: NCQA Elements are based on current 2020 HP Standards.

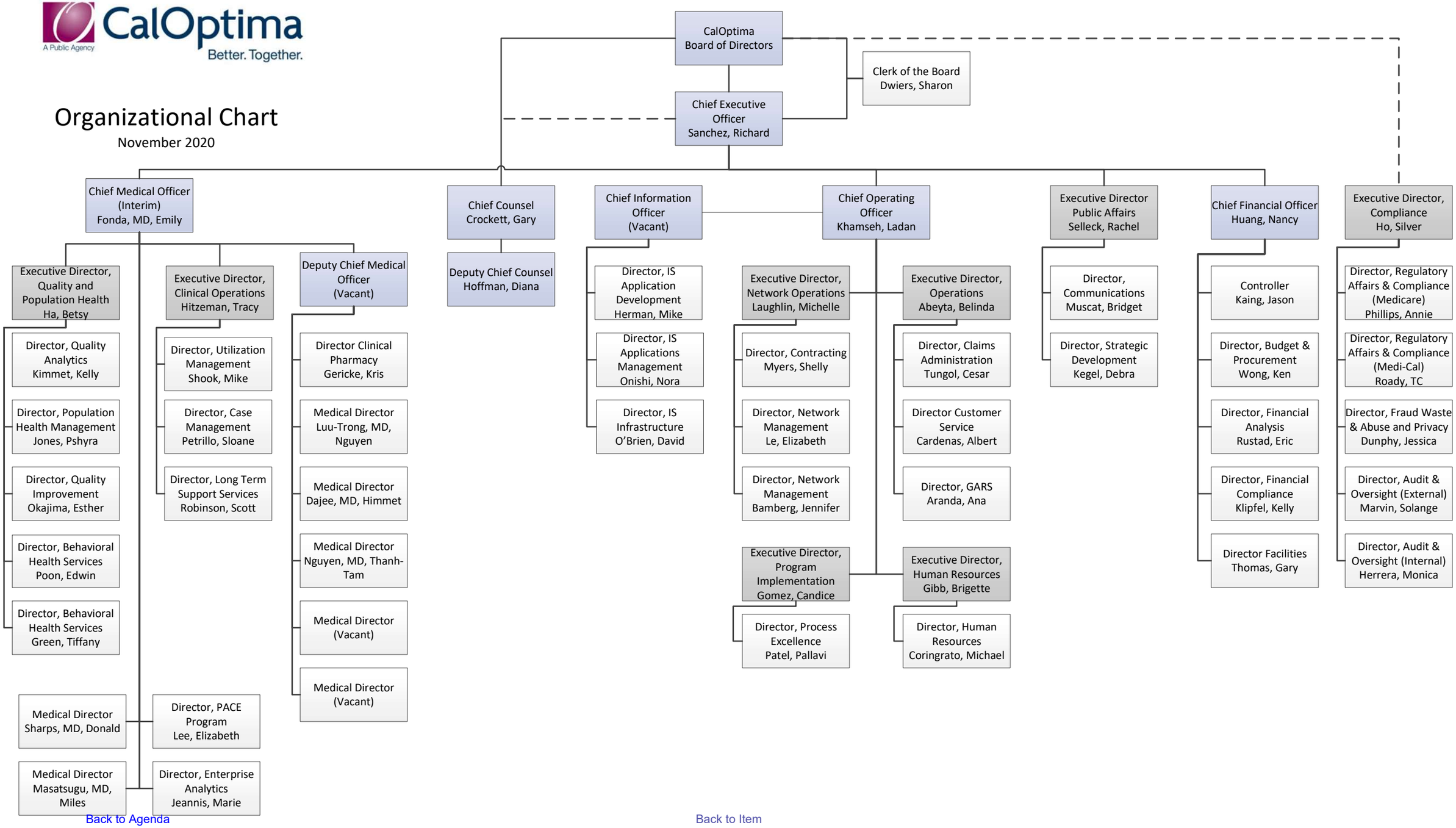
Back to Agenda Back to Item

APPENDIX C — ORGANIZATIONAL CHART

CalOptima
A Public Agency
Better. Together.

Organizational Chart

November 2020



Back to Agenda

Back to Item

CalOptima
A Public Agency
Better. Together.

2021

QUALITY IMPROVEMENT PROGRAM

2021 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Emily Fonda, M.D. **Date**
Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Mary Giammona, M.D. **Date**

Board of Directors Chair:

Andrew Do **Date**

Back to Agenda Back to Item

TABLE OF CONTENTS

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. The following meetings are open to the public: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits, and transportation. OCC also includes personalized services through the PCCs to ensure members receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

Program Initiatives

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE, and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, and the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. WPC was scheduled to terminate on December 31, 2020; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity, rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program, and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD) and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing-related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers for their housing-related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole-Person Care program, recuperative care services provide post-acute care for up to 90 days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with the Whole-Person Care program, and the CalOptima Board of Directors has authorized the extension of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.

- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole-Person Care program. These grant funds have been exhausted.

- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in person.

  Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima provides preventive screenings, chronic care, care coordination, and follow up.

- Hospital Discharge Process for Members Experiencing Homelessness—Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

It is expected that, effective April 1, 2021, the Department of Health Care Service (DHCS) will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing, prior authorizations, formulary administration, and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will

include physician-administered drug claims processing, prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only, and does not affect the OneCare/OneCare Connect, and PACE lines of business.

Virtual Care Strategy

In 2020, federal and state rules and regulations provided limited waivers for telehealth due to the COVID-19 pandemic that enabled CalOptima to accelerate its virtual care strategy under COVID-19 shelter-at-home measures. Members were able to receive appropriate health care services though telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.

2. Leverage existing delivery model where possible.

3. Be proactive in seeking out opportunities to innovate.

4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as: improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County.

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following HNs:

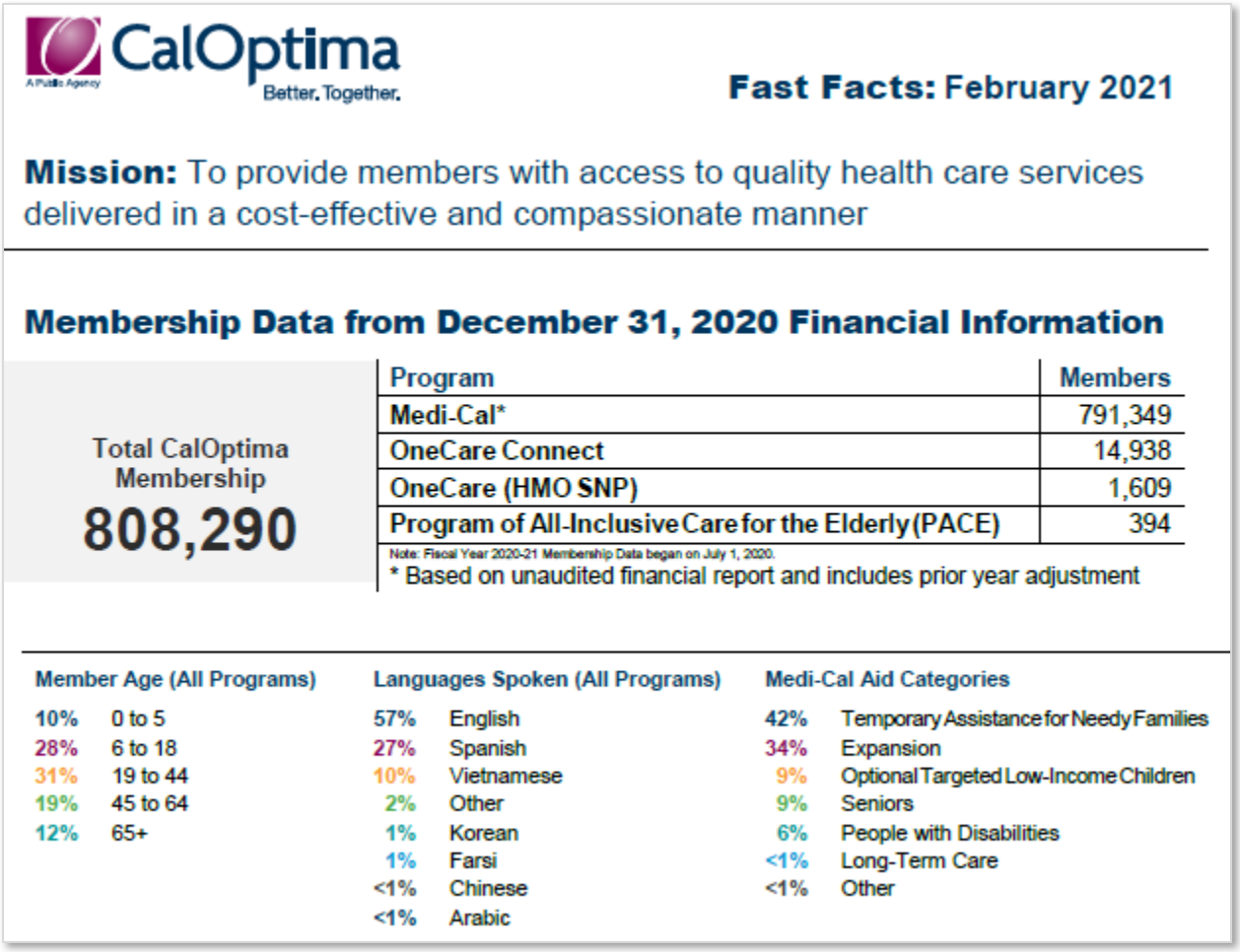
Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	

Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer service activities

MEMBERSHIP DEMOGRAPHICS



CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

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

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the CMS Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program—and in collaboration with its providers and community partners—CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.

- Maintain agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes.

- Supporting the provision of a consistent level of high quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers.

- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

  Ensuring certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority—HCA—which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.
- Promoting patient safety and minimizing risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related Organizational Providers (OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD-A network providers serving CalOptima's various populations:

- Supporting the agency's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently

- Continuously improving clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population

- Timely identifying important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high risks, and disease profiles for both acute and chronic illnesses, and preventive care

- Ensuring continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities

- Ensuring accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population

- Monitoring the qualifications and practice patterns of all individual providers in the network to deliver quality care and service

- Promoting the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances

- Ensuring the reliability of risk prevention and risk management processes

- Ensuring compliance with regulatory agencies and accreditation standards

- Ensuring the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans

- Promoting the effectiveness and efficiency of internal operations

- Ensuring the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs

- Ensuring the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values

- Ensuring compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's state and federal contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with federal and state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation and evaluation of the

overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons — medical safety net
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs — behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - OC SSA

- OC Community Resources Agency, Office on Aging
- OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent the broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC), has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: seven to nine seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are current recipients of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives: two to four seats

- Community-based organizations; or
- Consumer advocates

Members of the committee shall serve staggered two-year terms. WCM FAC meets at least quarterly and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care practitioner in the QI program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED,

Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the EDQ&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Case Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI are the directors of both Process Excellence and Strategic Development.

Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to state and federal requirements.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and must coordinate organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Public Affairs (Chief of Staff) is responsible for the oversight and measurement of CalOptima's communications, legislative, community relations and strategic development programs. The ED PA assists the CEO in carrying out organizational goals and planning, developing and implementing strategies to effectively communicate and implement the CalOptima mission with internal and external contacts, including employees, the public, members, providers, government officials, and the media.

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- Overseeing the analysis and evaluation of QI activities.
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation, and review of QI program activities.
- Identifying and prioritizing needed actions and interventions to improve quality.
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners, and delegated health networks are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization, and recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code §14087.58(b), Health and Safety Code §1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of Work Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates, and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of

application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-023. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations, and referrals for the "pain points" in health care that impact our members. In 2021, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2021 and MY 2022 CAHPS survey results.

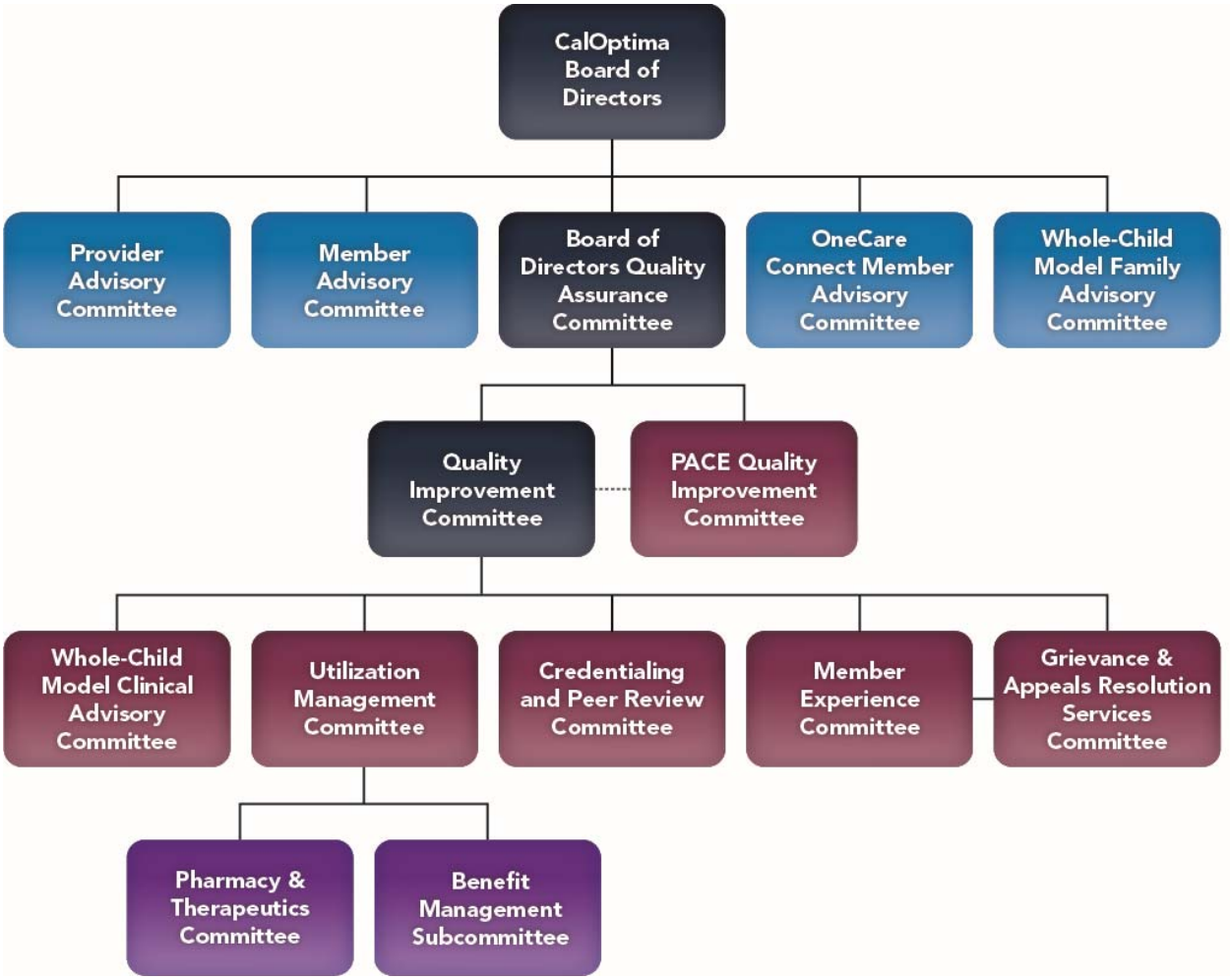
Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)

The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

Committee Organization Structure — Diagram



Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees—including contracted professionals who have access to confidential or member information—sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

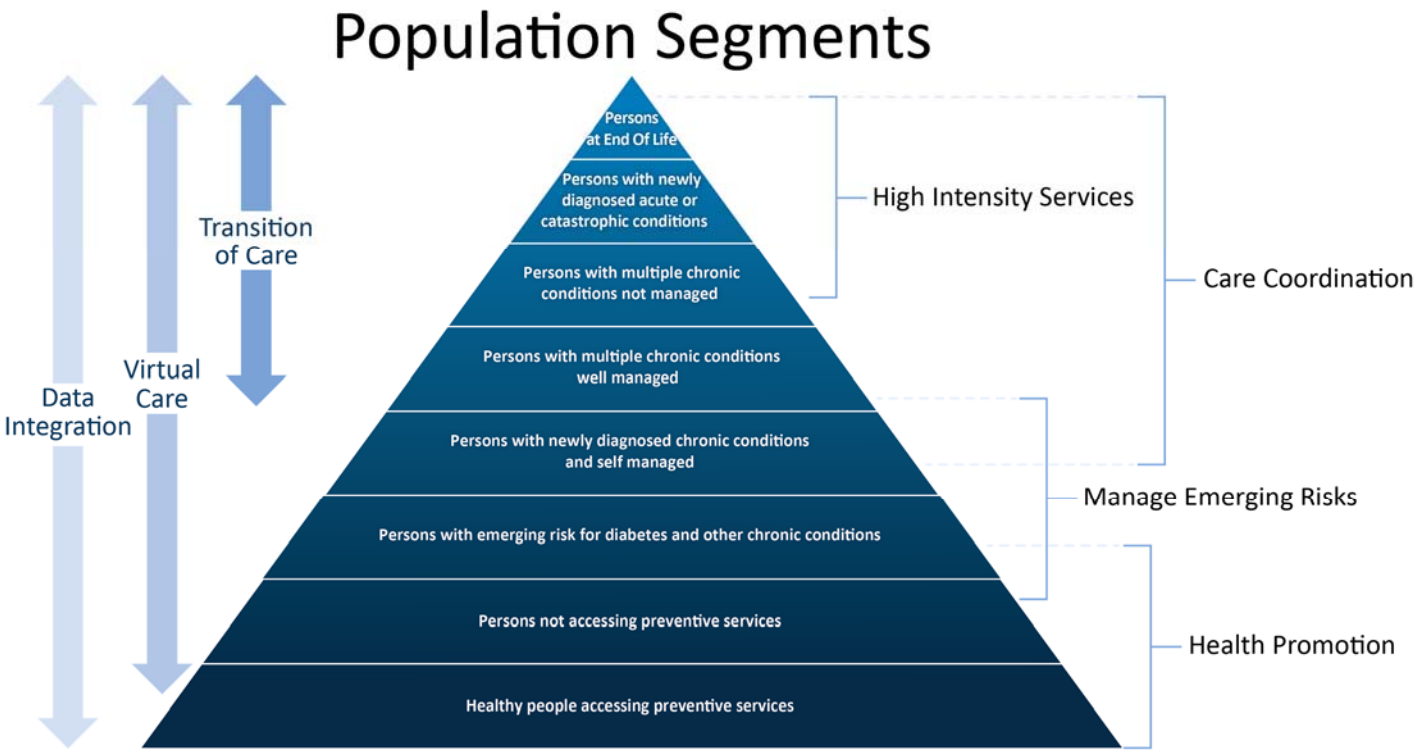
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the population based on their health needs, conditions, and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2021 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2021 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2021–2022 Strategic goals.

1. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.

2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.

3. Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0

These top three priority goals were chosen to be aligned with CalOptima's strategic objectives related to the pandemic, as well as continued goals related to access to care and NCQA Accreditation. The 2021 QI Workplan details the planned activities to meet the COVID-19 vaccine aim which include an immunization strategy, a targeted communication strategy and a member incentive strategy. The planned activities related to member's ability to access care are captured in the Virtual Care strategy as well as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). Finally, the goal of achieving NCQA-Accredited status in 2021 and maintaining the overall health plan rating is a high priority since CalOptima will be pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact

- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima strategic priorities and the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual patient care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2021 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2021 QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.

- Measures required by regulators, such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.

- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.

- Project coordination occurs through the various leadership structures: Board of Directors, management, QIC, UMC, etc., based upon the scope of work and impact of the effort.

- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality Measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers or predictors of the desired outcome measures or lag quality measure, such as HEDIS and Stars measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized.

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forums, and other ongoing ad hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both website and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes, and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on CalOptima's website, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation, and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED, Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)

- Supervisor, Quality Improvement, and Master Trainer (FSR)
- Supervisor, Credentialing
- QI Nurse Specialists
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:
- Quality Analytics HEDIS Manager
- Quality Analytics Pay for Value Manager
- Quality Analytics Network Adequacy Manager
- Quality Analytics Data Analytics Manager
- Quality Analytics Analysts
- Quality Analytics Project Managers
- Quality Analytics Program Coordinators
- Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:
- Population Health Management Manager (Program Design)
- Population Health Management Manager (Operations)
- Population Health Management Supervisor (Operations)
- Health Education Manager
- Health Education Supervisor
- Population Health Management Health Coaches
- Senior Health Educator
- Health Educators
- Registered Dietitians
- Data Analyst
- Program Manager

- Program Specialists
- Program Assistant

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operations)
Provides clinical operational oversight and leadership to the implementation, expansion and/or improvement of processes and services of the Behavioral Health Integration department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and UM for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management
Assists in the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective, and retrospective reviews that support UM medical management decisions, serves on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management
Leads the development and implementation of the Pharmacy Management (PM) program, develops, and implements PM department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics Committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
Responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment,

collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics
Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the road map. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the Enterprise Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization, and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.

- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.

- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.

- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.

- An evaluation of member satisfaction surveys and initiatives.

- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.

- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.

- Recommended changes included in the revised QI Program Description for the subsequent year for QIC, QAC, and the Board of Directors' review and approval.

Key Business Processes, Functions, Important Aspects Of Care And Service

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability

- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care, and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM and CM Programs and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities.
  - Drive improvement of quality of care received.
  - Minimize rework and unnecessary costs.

    - Measure the member experience of accessing and getting needed care.
    - Empower staff to be more effective.
    - Coordinate and communicate organizational information, both division and department-specific, as well as agencywide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agencywide practices that support accreditation and meet regulatory requirements.

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima and delegated to HNs and other sub-delegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and re-credentialing of OPs such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free- standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care provider (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR, and physical accessibility review survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with MMCD Policy Letter 14-004 and CalOptima policies. The Initial Medical Record Review shall be completed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that its contracted delegated HNs make certain that each member's medical record is maintained in an accurate manner that is current, detailed, organized and easily accessible to treating practitioners. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law.

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.

- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)

- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.

- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.
- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required.
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners.
- Facilitate satisfaction surveys for members.

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, Stars and HOS measures. This

information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2021 are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services, and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source, and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM programs**.** PHM programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members, and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management, Tobacco Cessation, Asthma, Immunizations, and Well Child Visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources, and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. A systemwide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner, and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of social determinates of health (SDOH). It proactively identifies those members in need of closer management, coordination, and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary

- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC, and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination, and basic are specific to SPD, OCC, and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
    - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
        - Roles and responsibilities of this team:
            - Basic case management, including advanced care planning
            - Medication reconciliation
            - Identification of member at risk of planned and unplanned transitions
            - Referral and coordination with specialists
            - Development and implementation of an ICP
            - Communication with members or their representatives, vendors, and medical group
            - Review and update the ICP at least annually, and when there is a change in the member's health status
            - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members

    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker

        - Roles and responsibilities of this team:

            - Identification and management of planned transitions
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services

- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization

- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at-high-risk individuals

- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.

- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC

In 2021, OC/OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician, or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2021 UM Program Description.

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved, and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture, and diverse needs

- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered

- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting

    - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    - Annual blood-borne pathogen and hazardous material training
    - Preventative maintenance contracts to promote keeping equipment in good working order
    - Fire, disaster, and evacuation plan, testing and annual training

- Institutional settings, including CBAS, SNF, and MSSP settings

    - Falls and other prevention programs
    - Identification and corrective action implemented to address post-operative complications
    - Sentinel events, critical incident identification, appropriate investigation, and remedial action
    - Administration of flu and pneumonia vaccines
    - COVID-19 Infection Prevention and Protective Equipment

- MRSA prevention program (Shield)

- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact, 24-hour access to telephonic interpreter services, member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- OC member materials are provided in three languages: English, Spanish and Vietnamese.
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity

- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards).
- Behavioral Health for MC, OC, and OCC lines of business
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, and peer review process on specific, referred cases
- Development of system-wide measures, thresholds, and standards
- Satisfaction surveys of members, practitioners, and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and organizational providers (OPs)
- Credentialing and re-credentialing of OPs
- Development of UM and Case Management standards
- Development of QI standards

- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2021 Delegation Grid.

See Appendix B — 2021 Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

Appendix A — 2021 QI Work Plan

APPENDIX B — 2021 DELEGATION GRID

APPENDIX C — ORGANIZATIONAL CHART

2021 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2021 QI Annual Oversight of Program and Work Plan
B. 2020 QI Program Evaluation
C. 2021 UM Program
D. 2020 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program updates (Health Network Quality Rating, MCAS, P4V)
M. Improvement Projects (All LOB)
QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC
N. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
O. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
P. Homeless Health Initiatives (HHI): Health Homes Program Phase 2
Q. Health Equity

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted to Board of Director's: Date:

Quality Improvement Committee Chairperson:

Emily Fonda, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, MD Date:

B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
C. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*, which is a NCQA Accreditation Measure

D. Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations
B. Blood Lead Screening

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Virtual Care Strategies

VIII. QUALITY OF SERVICE- Member Engagement

A. Improve Member Experience- Member Engagement

IX. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure.
   OCC Quality Withhold measure.
B. Quality of Care Grievances and Potential Quality Issue
   (GARS/PQI) Processing
C. Post-Acute Infection Prevention Quality Incentive (PIPQI)
D. Orange County COVID Nursing Home Prevention Program.

E. LTC Facility Transfer Plan due to COVID-19

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT								
2021 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2021 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by February 2021	Betsy Ha				
2020 QI Program Evaluation	Complete Evaluation 2020 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by February 2021	Betsy Ha				
2021 UM Program	Obtain Board Approval of 2021 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by February 2021	Mike Shook				
2020 UM Program Evaluation	Complete Evaluation of 2020 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by February 2021	Mike Shook				
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Pshyra Jones				
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima				
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Ana Aranda				
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook				
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD				
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital				
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V). Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital				
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures- Due March 2nd. **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo/Cathy Osborn				
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achive program milestones quarterly and annual performance goals	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Quarterly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Quarterly Adoption of Report	Edwin Poon				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Sloane Petrillo				
Homeless Health Initiatives (HHI): Health Homes Program Phase 2	Improve Health & Access to care for enrolled members	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI 5. Focus on telephonic outreach d/t COVID-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Quarterly Report	Sloane Petrillo				
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Pshyra Jones/Betsy Ha/Marie Jennis				
II. QUALITY OF CLINICAL CARE- Adult Wellness								
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	**MY2020 Goal:** **CCS -** MC 60.65% **COL** - OCC 73%, OC 62% **BCS** -MC 58.67%, OCC - 76%, OC - 76%	1) Continue $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Track the number of mammograms scheduled through targeted outreach. 4) Member Health Rewards RFP and Vendor Contract	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (16 and over).	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a.They are now eligible to be vaccinated. b.Where they need to go to be vaccinated (when available) c.This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health								
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2020 Goal:** 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:18.20 %	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	12/31/2021	Edwin Poon	Yes			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**MY2020 Goal:** MC - Init Phase - 43.41% MC -Cont Phase - 55.05%	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	12/31/2021	Edwin Poon	Yes			
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS MY2020 Goal:** **MC:NA**	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	12/31/2021	Edwin Poon	Yes			
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 41% OC 56% OCC 56%	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	12/31/2021	Edwin Poon	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE- Chronic Conditions								
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**HEDIS MY2020 Goal: (A1C Poor Control)** MC:37.47% OC: 19.46% OCC: 19.46%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Member Health Rewards RFP and Vendor Contract 3) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS MY2020 Goal: (Diabetric Eye Exams)** MC: 58% OC: 67.5% OCC: 67.5%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
V. QUALITY OF CLINICAL CARE- Maternal Child Health								
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	**HEDIS MY2020 Goal:** Prenatal 83% Postpartum 65%	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	12/31/2021	Ann Mino	Yes			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness								
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	**HEDIS MY2020 Goal:** MC 68.37%	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Blood Lead Screening	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2020 Goal**: Lead Screening 50th percentile 73.11%	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials, 4) Prop 56 provider value based payments for Blood Lead Screening	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access								
Improve Access: Reducing gaps in provider network	Contract with a minimum of 25% of targeted providers identified by the network adequacy work group.	1) Actively recruit hard to access specialties for CCN	12/31/2021	Michelle Laughlin/Jennifer Bamberg				
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists by 10 percentage points.	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After All Attempts** from 28.3% to 25.0%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Virtual Care Strategies	Increase telehealth utilization rate from 24.1% to 30% (visit count/# members) Increase member telehealth usage from 8.8% to 10% (teleheatlh member count/# members)	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	12/31/2021	Marsha Choo/Rick Cabral				
VIII. QUALITY OF SERVICE- Member Engagement								
Improve Member Experience: Member Engagement	Increase member engagement via member portal.	1) Member Portal 2) Member Outreach Calls	12/31/2021	Mauricio Flores/Andrew Tse				
IX. SAFETY OF CLINICAL CARE								
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2020 Goal**: MC - NA OC 8%;OCC 0.85 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	12/31/2021	Mike Shook	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	Provide clinical recommendations to members with a quality of care grievance within 30 days.	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	12/31/2021	Laura Guest/Ana Aranda				
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2021	Cathy Osborn/Scott Robinson	Yes			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COVID-19 as soon as possible 2) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COVID 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www.ucihealth.org/stopcovid	5/31/2021	Cathy Osborn/Scott Robinson				
LTC Facility Transfer Plan due to COVID-19	Transfer 100% of CalOptima members to other facilities within 5 days of evacuation notice.	1) Train all LTSS staff in LTC operational DTP: LTC015 LTC facilities planned and unplanned closure process. 2) Monitor all nursing facilities for COVID_19 positive rates in members and facility staff 3) Identify high-risk facilities that hae COVID-19 related staffing shortages and high infection rates that my require evacuation. 4) Identify and maintain a log of available nursing facility beds that members could be transferred to.	12/31/2021	Scott Robinson				

APPENDIX B — 2021 DELEGATION GRID

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.2.4	PHM2D: Segmentation-PHM	X		X	
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X		X	
3.4.2	NET4B: Continued Access to Practitioners	X		X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA for Interim Surveys only
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				NA for Medicaid
4.9.6	UM9F: Appeals Overturned by the IRO				NA for Medicaid
4.9.7	Provider Appeals Provider Complaint Processing	X	X	X	
4.10.1	UM10A: Written Process				NA for Medicaid
4.10.2	UM10B: Description of the evaluation Process				NA for Medicaid
4.11.1	UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X	
4.11.2	UM11B: Pharmaceutical Restrictions/Preferences	X		X	
4.11.3	UM11C: Pharmaceutical Patient Safety Issues	X		X	
4.11.4	UM11D: Reviewing and Updating Procedures	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.11.5	UM11E: Considering Exceptions	X		X	
4.12.1	UM12A: UM Denial System Controls	X	X	X	
4.12.2	UM12B: UM Appeal System Controls	X		X	
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				NA due to Carve out
5.7.4	CR7D: Assessing Medical Providers	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.5	CR7E: Assessing Medical Providers				NA due to Carve out
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations				NA for Medicaid
6.3.2	ME3B: Communication with Prospective Members				NA for Medicaid
6.3.3	ME3C: Assessing Member Understanding				NA for Medicaid
6.4.1	ME4A: Functionality: Website	X		X	Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X		X	Not Required for Renewal Survey

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			May not be Delegated
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Claims Processing Timeliness of Claims and Interest on Late Claims	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR)	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
7.1.7	Third Party Liability (TPL) CalOptima policy FF.2007: Reporting of Potential Third-Party Liability.	X	X	X	
7.1.8	Family Planning Services CalOptima Policy GG.1118: Family Planning Services, Out-of-Network	X	X	X	

Note: NCQA Elements are based on current 2020 HP Standards.

Back to Agenda Back to Item

APPENDIX C — ORGANIZATIONAL CHART

CalOptima
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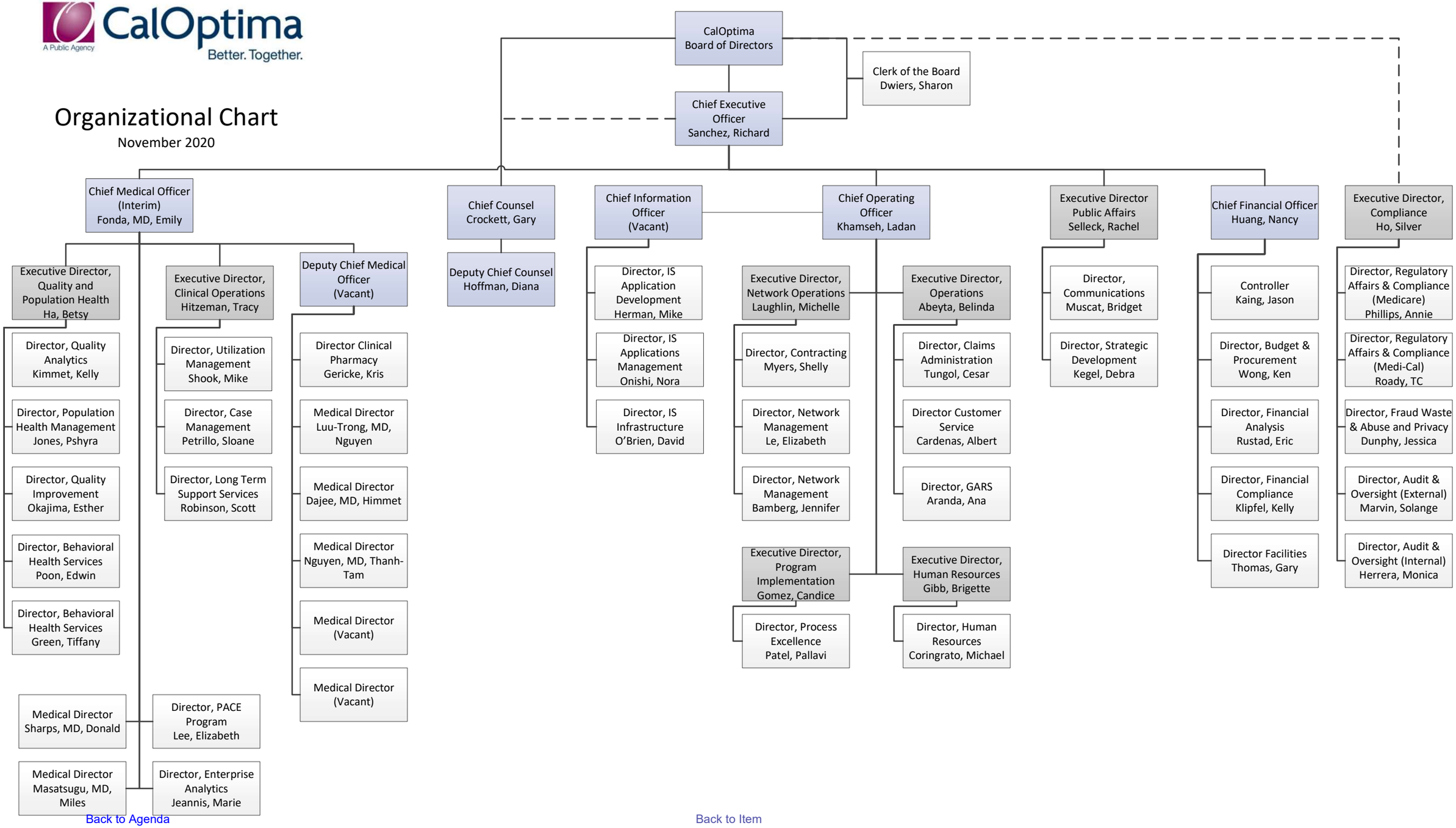
Organizational Chart

November 2020



Back to Agenda

Back to Item

A Public Agency

CalOptima

Better. Together.

2021 Quality Improvement Program and Work Plan

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021

Esther Okajima
Director, Quality Improvement

Back to Agenda Back to Item

2020 QI Accomplishments

- Recognized by DHCS as the highest performing Medicaid plan in California.
- Met all DHCS Managed Care Accountability Set (MCAS) measures required to achieve Minimum Performance Level (MPL) in measurement year (MY) 2019.
- Performed successful incentive outreach to members in MY 2019 to obtain preventive care, which demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, breast and cervical cancer screening
- Demonstrated the highest ACE screening rate among MCPs (6.3% vs State Average of 3 %)

Back to Agenda

Back to Item

CalOptima
A Public Agency

2020 QI Accomplishments (con't)

- Recognized and rewarded outstanding performance of Health Networks and CalOptima Community Network through comprehensive Pay for Value (P4V) performance measurement program.
- Extended CalOptima's Homeless Health Initiative which included Clinical Field Team (CFT) and Community Health Center (CHC) efforts.
- Implemented Post-acute Infection Prevention Quality Initiative (PIPQI), as well as participated in the Orange County Nursing Home Infection Program to reduce spread of COVID-19
- Responded to COVID-19 pandemic and amplification of health disparities for persons of color

2020 QI Evaluation Recommendations

- Develop comprehensive COVID-19 strategy to mitigate impact and expand virtual care strategies to increase access for members
- Continue member “health rewards” incentive program, specifically for preventive screenings
- Expand member incentive to promote COVID-19 vaccine acceptance
- Intensify targeted member outreach by utilizing multiple modes of communications
- Prioritize data bridge efforts to improve data exchanges to boost measures now considered administrative

2021 QI Program Description

- QI Program Changes and Updates
- QI Program Goals:
  - Aim for 70% COVID19 vaccine rate as a stretch goal to ensure member safety during COVID19 pandemic.
  - Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.
  - Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0

2021 QI Program Work Plan (Appendix A)

- COVID-19 Related Initiatives
- Added and Retired Initiatives
  - Program Oversight
  - Quality of Clinical Care
  - Safety of Clinical Care
  - Quality of Service

2021 QI Program Delegation Grid (Appendix B)

- CalOptima Responsibilities
- Activities Delegated to Health Networks
- Activities Delegated to Kaiser

Questions

Back to Agenda

Back to Item

CalOptima
A Public Agency

Our Mission

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

Back to Agenda

Back to Item

CalOptima
A Public Agency

CalOptima Program of All-Inclusive Care for the Elderly

2020

Quality Improvement Plan

Annual Evaluation

Back to Agenda

PACE CalOptima A Public Agency Better. Together.

SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

_____ _____

Miles Masatsugu, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Mary Giammona, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Andrew Do **Date**
Supervisor, First District

TABLE OF CONTENTS

2020 CalOptima PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

The COVID-19 pandemic in 2020 was a year of unprecedented challenges impacting all areas of everyone's lives. CalOptima PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus.

In mid-March, 2020, when the pandemic was declared, the scope of delivery of health care services had to instantly adjust to numerous health orders and recommendations from the national, state and county levels. Our first response at that time was to close the PACE Center apart from our in-house clinic services. All guests, employees and participants were screened upon entry into the PACE Center and over 70% of our staff were re-assigned to temporary telework.

Understanding the profound importance of maintaining contact with PACE participants, we implemented daily "wellness calls" to check in on the well-being of our participants. Since the onset of the pandemic, over 20,000 wellness calls kept participants connected with PACE.

The PACE Clinic continued operations and a new triage system was developed to accommodate requests from our participants for urgent and same day visits with our medical providers. Understanding the importance of continuing to provide preventive health services, we implemented drive-through immunization hours which eventually also led to drive-through COVID-19 testing.

At the end of April, PACE along with others in the health care community, received a waiver from the Centers for Medicare & Medicaid Services (CMS), to provide the flexibilities needed to take care of patients during the public health emergency. This improved our ability to provide services beyond the existing walls of the PACE Center and assume a more home-based model, called "PACE without Walls." We developed a service delivery matrix to continue providing existing PACE care services, including medical management, nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services and personal care services. Training and education were provided to staff who delivered care services at participants homes. Those services started in June. Additional "PACE without Walls" services delivered by our transportation team, included monthly care packages containing items such as activity books, calendars, and socks. Participants eagerly awaited these care packages and the opportunity to connect with others beyond their home.

When we recognized that the pandemic will inevitability change the landscape of health care delivery for the long-term, we pursued telehealth platforms. In early November, we implemented our newly contracted telehealth system and diligently worked with PACE participants to determine access to mobile devices, their level of comfort with using the devices, broadband capabilities in their homes, and whether they needed assistance to install the telehealth application. The telehealth service delivery has expanded our access with participants, not just during the pandemic, but also post-pandemic. It should be noted, however that face-to-face encounters are always preferred, and will always be utilized for initial participant assessments or when telehealth is not an option.

Despite the COVID-19 pandemic being declared in mid-March, we continued to enroll new participants through a virtual modality. Naturally, our enrollment goals were not met, although we have seen an increase over the latter part of fourth quarter. When CalOptima PACE opened for operations on October 1, 2013, we had 13 participants. We have seen steady growth in enrollment. At the end of 2020, we had 394 participants. The multi-cultural background and the diversity of our participant population provides a very vibrant and engaging environment. Currently, 10 languages are spoken by our participants, with 82% of the participants speaking English as their second language. Out of our 394 participants, the preferred languages are 58% Spanish, 18% English and 16% Vietnamese. Other languages spoken include Korean, Tagalog, Chinese, Hindu, Urdu, and Telugu.

The purpose of the CalOptima PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes, and reduce the potential risk to safety and health of PACE participants through ongoing risk management. This is done via data-driven assessments of the program, which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

The goals of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff. The 2020 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2021 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima PACE QI Plan is developed annually by the PACE QI Committee (PQIC). It is then reviewed and approved by the CalOptima Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors. The 2020 PACE QI Plan was reviewed and approved by the CalOptima Board of Directors on April 20, 2020.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI manager will ensure timely collection and completeness of data with the support of the PACE QI program specialists. Overall, oversight of PACE QI is provided by the CalOptima Board of Directors.

The CalOptima PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima's PACE participants.

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2020, CalOptima PACE accomplishments include:

1. Responded quickly to the COVID-19 pandemic, to follow federal, state, and local guidance.
2. Implemented a clinic triage system to continue to provide health care access to participants during the pandemic.
3. Implemented a telehealth platform that enabled participants to "visit" their providers from their homes.
4. Implemented PACE without Walls which provided skilled and non-skilled services to participants outside of the PACE Center during government mandated stay-at-home orders.
5. Connected with participants through more than 20,000 wellness calls, and more than 32,000 home delivered meals and care packages.
6. Provided aggressive infection control training to staff.
7. Deployed more than 70% of staff to work remotely from their homes.
8. Provided weekly COVID-19 updates to the leadership team and monthly updates during our all-staff meetings.
9. Completed two Quality Initiatives: Advance Health Care Directive and Immunizations.
10. Met 21 out of 26 Work Plan goals.
11. 93% of participants received their annual influenza vaccine.
12. 98% of participants received the Pneumococcal vaccine.
13. Achieved respiratory infection rates in the elderly 35% lower than national benchmarks.
14. Implemented enhanced care coordination program for participants with dialysis.
15. 99% of participants had their medications reconciled within 30 days of hospital discharge.
16. Provided prompt review by clinical pharmacist of specialty medications ordered by outside specialists.
17. Performed retrospective reviews of medication utilization daily and monthly. Recommendations were immediately addressed with the PACE provider and/or IDT.
18. Only 0.64 falls per 1000 members month occurred at the PACE Center in 2020.
19. Quality of Diabetes Care
    a. 98% of participants with diabetes completed an annual eye exam.
    b. 100% of participants with diabetes had nephropathy monitoring.
    c. 87% of participants with diabetes had their blood pressure controlled.
20. Utilization:
    a. Only 1.7% participants were placed in long-term care in 2020.
    b. Refined the PACE Emergency Room (ER) Diversion program.
    c. Continued to provide in-house specialists including podiatry, dental, and optometry for improved access and coordination of care.
    d. Morning clinical huddles were incorporated into the IDT meetings for all teams.
21. Transportation:
    a. More than 35,000 trips with an on-time performance of 98%.

22. Participant Satisfaction
    a. 89% overall satisfaction with care received compared to the national average of 88.3%.
    b. 93% said the services they received at PACE improved or maintained their quality of life.
    c. 91% said they would recommend the program to a close friend.
    d. 6 of the 10 participant satisfaction domains scored higher than the national average.
23. 100% of staff competency assessments were completed. Year-round staff trainings covering a broad area of topics included coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests and rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings was high, especially as it pertains to the unique needs of the population. This was accomplished and evidenced by:
    a. The ongoing HPMS and QI individual metric data collection and analysis.
    b. The ongoing PACE QI initiatives.
    c. The monitoring of member grievances and complaints, and regular review of delegated entities.
    d. The monthly meeting with the transportation vendor.
    e. The daily morning inpatient and nursing facility clinical reviews.
    f. By the ongoing infection control activities.
    g. Collaboration with the Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality breaches, security, etc.
    h. The annual approval of up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
    i. The Redesigned PACE Clinic Workflow/Triage to efficiently address participant care issues during the 2020 COVID-19 pandemic.
    j. Implemented a telehealth platform that enabled enhanced access to care during the pandemic.
    k. Developed a relative value unit (RVU) measurement to monitor the productivity of staff, including those deployed as teleworkers.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners, was accomplished and evidenced by:
    a. The daily Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Addition of hospital and nursing home attending physicians to the IDT.

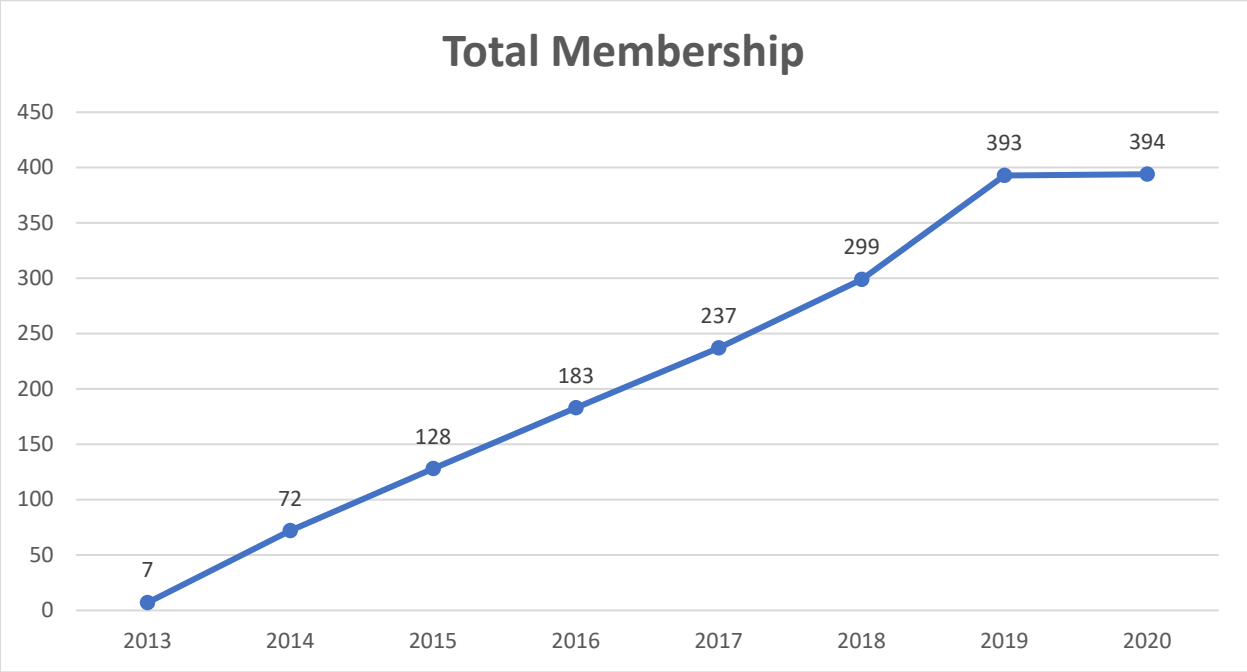
    c. Addition of preferred specialists that agreed to participate in IDT.
    d. The coordination of care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population was accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. A nurse practitioner that specializes in podiatric procedures, an optometrist, and a dentist at the PACE clinic to see and treat the PACE participants.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service was accomplished and evidenced by:
    a. The credentialing and peer review process.
    b. Annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances was accomplished and evidenced by:
    a. The improvements in the PACE Participant Satisfaction Survey.
    b. The summary of grievance and appeals activities.
    c. The ongoing PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes were accomplished and evidenced by:
    a. The QI activities which occur around all Unusual Incidents.
    b. Physical therapy driven groups such as Fall Prevention Group, Fall Committee, Fallers Anonymous and Matter of Balance groups.
    c. Root cause analysis done on Unusual Quality Incidences.
8. Compliance with regulatory agencies and accreditation standards was accomplished and evidenced by:
    a. The successful submission of data as required by CMS and DHCS.
9. Compliance with clinical practice guidelines and evidence-based medicine was accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The adoption of Uptodate.com clinical practice standards.
    c. On-going staff training.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently was accomplished and evidenced by:
    a. Tracking, trending, and analyzing utilization management (UM) data monthly.
    b. The provider incentive program.
    c. The coordination of care found in the ER Diversion Program.
    d. The weekly PACE management team meetings.
    e. Full implementation of the PACE 2.1 initiative, promoting program growth and employee engagement.
    f. Continued expansion of *PACE without Walls* program.
    g. The participation in the CalOptima QI, UM, and Credentialing and Peer Review Committee meetings.
    h. The participation in the CalOptima Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

i. Two quality initiatives which focused on participant immunizations and advance health care directives.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima PACE offers a community-based program that provides all necessary medical care, coordination, and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission eight years later. At the end of 2013, we had seven participants enrolled and now, seven years later, we have 394 participants.



As illustrated in the first membership graph, PACE has seen a steady enrollment trend over the years. In 2018, it was a particularly notable year for enrollment, as this was the year we implemented "PACE 2.0" a collaborative PACE-team effort focused on program growth and expansion. The tenets of PACE 2.0 were to create a context for change by developing a process for optimizing enrollment and establishing organizational capacity to promote continued growth.

One of the ways in which capacity for growth was championed was through partnerships with area Community-Based Adult Service (CBAS) centers. These partnerships became alternative care sites (ACS) for participants, and through the addition of these sites we were able to increase our enrollment capacity. Pre-pandemic, over 60 PACE participants received PACE services through these alternative care sites. Despite the substantial challenges that PACE faced with the COVID-19 pandemic in 2020, we continued to enroll participants into our program and persist in providing essential health services to our communities. In 2021, our goals for program growth remain intact and strategies are already being put into place to accommodate participants post-pandemic. We expect to return to our 2019 growth rates once the pandemic subsides and we can again go out into the community to market the program.

2020 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI20.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 19, 2020.

QI20.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 19, 2020.

QI20.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2020.

Goal: Not Met

Data/Analysis: 93% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

With a year-end vaccination rate of 93%, we fell short in meeting our goal by one percentage point. This was despite an aggressive flu vaccination campaign with weekly drive through vaccine clinics. All participants who have not been vaccinated have had discussions with our providers and have refused. Vaccines were ordered in late spring from our distributor and we began to vaccinate participants when vaccines arrived in mid-August. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the PCP and RN's who personally reached out to the unvaccinated participants. It is important to note that enrollees in the month of December, were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

PACE staff also received their flu vaccine through employee health services, expanding the scope and engagement of the flu vaccine campaign. It is important to note that CalOptima PACE reported zero influenza outbreaks among our participants or staff in 2020.

Due to the COVID-19 pandemic, many participants were reluctant to step out of their homes and into the community, which could potentially expose them to the COVID-19 virus.

Our 2020/2021 vaccination efforts will continue through quarter 1 of 2021 where we will continue to reach out to the unvaccinated.

QI20.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their pneumococcal vaccination by December 31, 2020.

Goal: Met

Data/Analysis: 98% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2020, 98% of our participants had received the pneumococcal vaccine, exceeding our goal. This was an improvement from the 95% who met this metric in 2019. Much of our success is attributed to the implementation of the following protocols:

a. Designated Immunizations as a Quality Initiative with quarterly dashboard presentations during PACE Quality Improvement Committee meetings.

b. Established standing orders and standardized procedures in vaccine administration. This eliminated the need to wait for a physician order by delegating this responsibility to a registered nurse who has demonstrated the required competency.

c. Utilize the electronic medical record's (EMR) quality analytics, and other data platforms to track missed opportunities for immunization.

d. Implemented drive-through vaccination clinics throughout the year.

e. Undertook outreach by PACE PCP's to those participants who refused the vaccine.

The PACE QI department provided detailed monthly reports which specified which participants still needed the vaccination. It was then shared with all participant's medical providers. As with previous years, one of our challenges was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines.

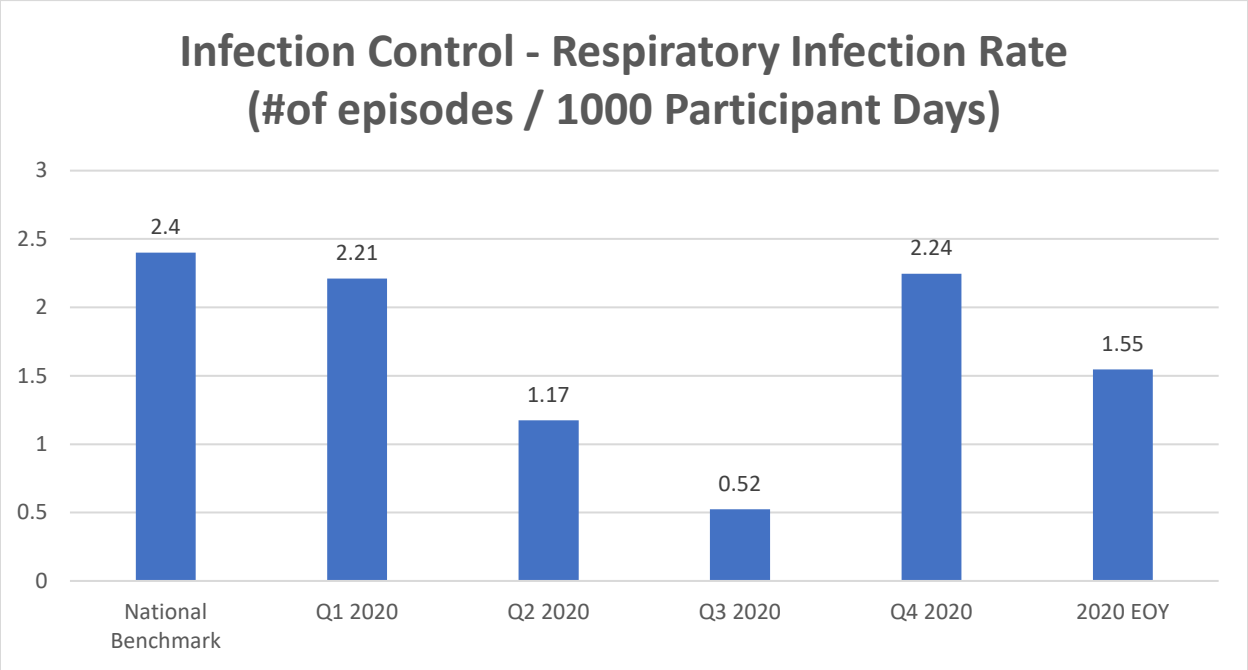
In 2021, we plan to continue with existing strategies to meet our goals for the pneumococcal vaccine. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

QI20.05 Reduce common infectious in PACE participants (Respiratory Infection)

Goal: Maintain common respiratory infection rate less than the following national benchmarks: Respiratory Tract 0.1–2.4 episodes/1000 participant days.

Goal: Met

Data/Analysis: The 2020 rate was 1.55 episodes per 1000 participant days.



Summary and Key Findings/Opportunities for Improvement:

Despite the COVID-19 pandemic, we were able to conclude the year below the national benchmark. As in previous years, we focused heavily on infection control in 2020 with increased surveillance due to the emergence of COVID-19. At the onset of the pandemic, we ceased day center on-site activities for participants and reassigned eligible staff to telework status. We screened all individuals accessing the PACE Center and enacted a mask mandate for all individuals at the center. We ordered and tracked our personal protective equipment (PPE) inventory and enhanced environmental controls such as surface disinfection. We provided a comprehensive infection control training which covered blood borne pathogens, droplet vs. aerosol COVID-19 transmission, handwashing, and proper use of PPE. In June, following the guidance of Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency, we conducted drive thru COVID-19 testing for our participants who were symptomatic. All positive COVID-19 participants received daily phone calls from their PCP and ancillary health staff. Over the course of months, we expanded COVID-19 testing to participants with known positive contacts and implemented contact tracing for those participants who had acquired the virus through community transmission. When we realized that the upcoming influenza season may coincide with the COVID-19 pandemic, we began our influenza vaccination program as soon as

the vaccine was released. This assured a high number of vaccinated individuals early in the flu season thereby reducing potential influenza outbreaks among our participants which could exacerbate the COVID-19 pandemic. We also included an aggressive campaign to vaccinate participants with the two pneumococcal vaccines, PCV13 and PPSV23. Other actions taken to minimize the risk of respiratory infections were interventions such as providing home nebulizer machines to participants with COPD, CHF and asthma.

Keeping abreast of the trending of the COVID-19 virus and anticipating surges allowed us to plan for the "worst case scenarios" and implement a solid infection control plan.

QI20.06 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2020.

Goal: Not Met

Data/Analysis: 94% of participants enrolled in the PACE program for 6 months had POLST by the end of 2020.

Quarter 2020	Completion Rate
Q1	99%
Q2	95%
Q3	94%
Q4	90%
EOY	**94%**

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal. With stay-at-home orders in place for most of the year, the one-on-one encounter necessary for a POLST completion was not feasible. However, end-of-life care which is consistent with the participants wishes are still reviewed with the participant and the PCP during telehealth encounters. End-of-life and palliative care discussions continue to be integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's care plan.

QI20.07 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100% of participants have functional status assessment completed every 6 months by the disciplines required by CMS.

Goal: Met

Data/Analysis: 100%

Functional Status Assessment	Q1 2020	Q2 2020	Q3 2020	Q4 2020	EOY
Charts with All Assessments	399	391	377	393	1560
Census at End of Quarter	399	391	377	393	1560
Rate	**100%**	**100%**	**100%**	**100%**	**100%**

Care for Older Adults: Functional Status Assessment				
	2020 Star Rating Measure Cut Points			
MY 2020 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	55% to 71%	71% to 85%	85% to 93%	**≥ 93%**

Summary and Key Findings/Opportunities for Improvement:

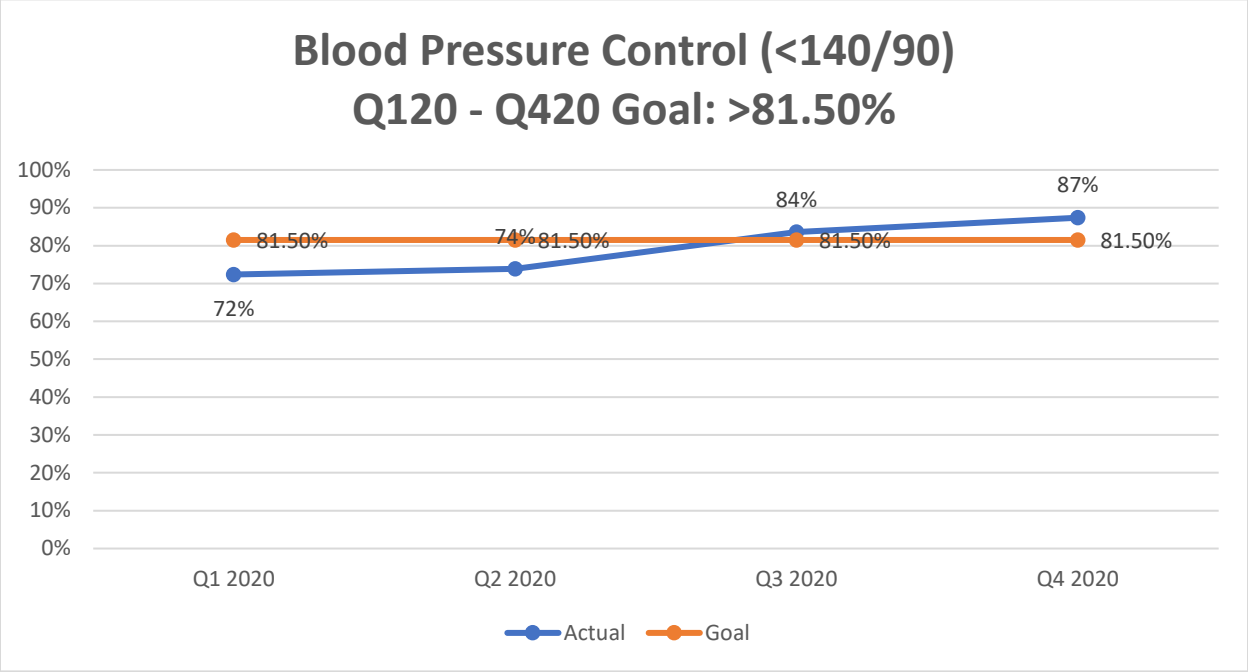
Annual and semi-annual functional assessments are critical components in determining a participant's medical, psychosocial, and cognitive status. These assessments assist in identifying risk factors and interventions necessary for optimal outcomes. A key factor in achieving this has been the monthly reports generated by the QI department specifying which participants required the functional assessment. This prompts the IDT disciplines to schedule the appointment, communicate with the family/caregiver regarding the appointment and coordinate transportation for the participant. Our success in this element places us comparable to a 5-Star Medicare rating based on the 2020 Star Rating Measure Cut Points.

QI20.08 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 81.50% of Diabetics will have a Blood Pressure of <140/90

Goal: Met

Data/Analysis: The 2020 final rate was 87%.



Diabetics with Controlled Blood Pressure					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
87%	64.72%	69.53%	76.56%	81.50%	**84.91%**

Diabetes Care: Blood Sugar Controlled				
	2020 Star Rating Measure Cut Points			
MY 2020 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
87%	37% to 61%	61% to 72%	72% to 85%	**≥ 85%**

Summary and Key Findings/Opportunities for Improvement:

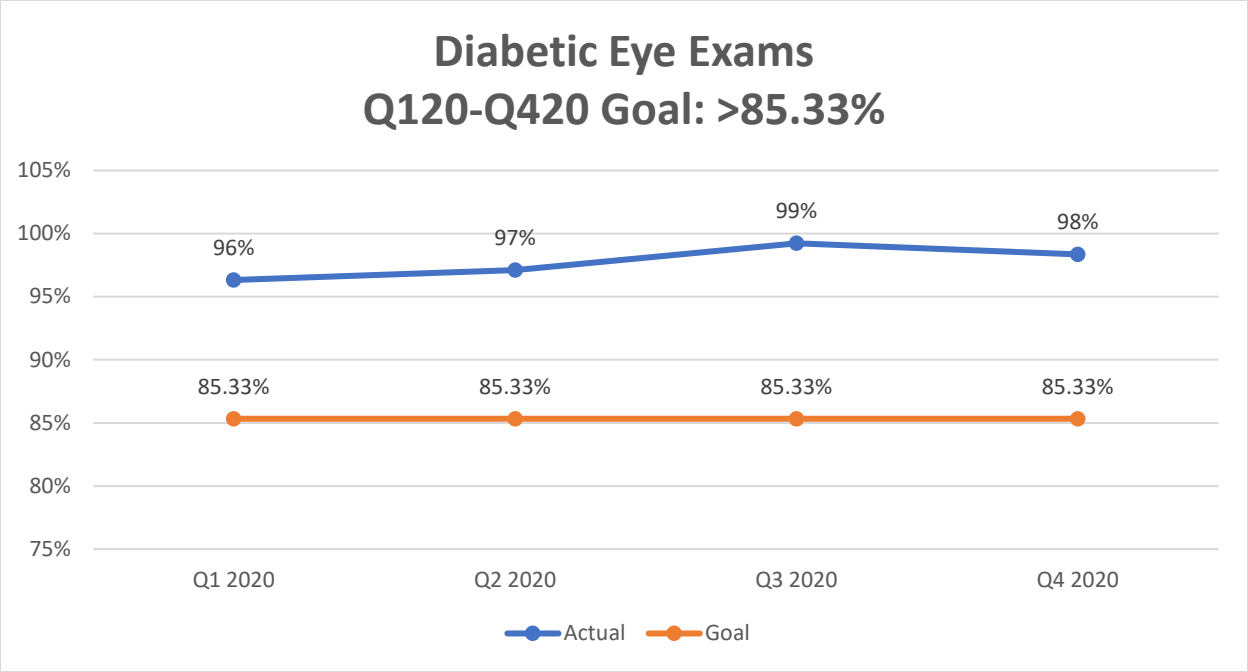
We exceeded our goals in this element and increased our performance by 3 percentage points from 2019. Prompt identification of participants with poor control of their blood pressure and monthly generated reports contributed to the success in this element. Those participants with out-of-range numbers are monitored leading to direct interventions such as medication adjustments. Our in-house pharmacist also provided recommendations for those participants who have difficulty maintaining adequate blood pressure control. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile and a 5-star Medicare rating based on 2020 Star Cut Points.

QI20.09 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 85.33% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2020 final rate was 98%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
98%	67.75%	75.28%	82.00%	85.33%	**87.10%**

Diabetes Care: Eye Exam					
	2020 Star Cut Points				
MY 2020 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
98%	<63%	63% to 69%	69% to 73%	73% to 78%	>/= **78%**

Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 98% of diabetic participants that received an annual eye exam in 2020. With the assistance of monthly reports generated by the PACE QI team, medical providers were alerted to those participants who required eye exams. Those participants were then scheduled for an appointment with their PCP on an annual and semi-annual basis. Our 2019

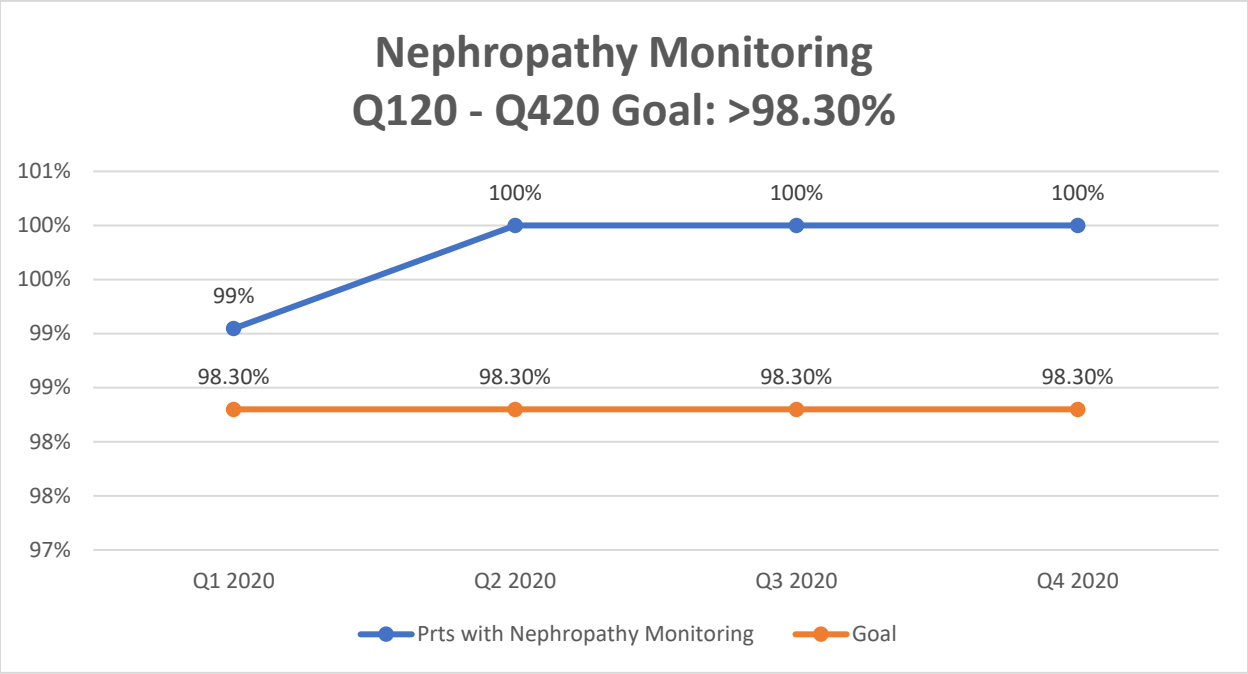
purchase of optometry equipment allowed us to provide immediate access to our participants for diabetic eye exams with a contracted optometrist. In addition, contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95% percentile.

QI20.10 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.30% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2020 final rate was 100%.



Comprehensive Diabetes Care: Medical Attention for Nephropathy					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
100%	94.19%	95.95%	97.08%	98.30%	**98.78%**

Comprehensive Diabetes Care: Nephropathy Monitoring				
	2020 Star Rating Measure Cut Points			
MY 2020 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	NA	80% to 95%	95% to 97%	**≥ 97%**

Summary Key Findings/Opportunities for Improvement: In 2020, 100% of our diabetic participants received nephropathy monitoring, exceeding our success from 2019. The PACE QI department works closely with the medical team in providing data generated reports identifying which participants required nephropathy screening/monitoring. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile.

QI20.11 Decrease the rate of participant falls occurring at the PACE day centers

Goal: <6.65 Falls per 1000 member months occurring at the PACE day centers (ACS and Garden Grove PACE)

Goal: Met

Data/Analysis: The 2020 rate was 0.64 falls per 1000 member months.

Quarter 2020	# Falls	Member Months	# Falls Per 1000 Members Months
Q1	3	1191	2.52
Q2	0	1192	0.00
Q3	0	1143	0.00
Q4	0	1173	0.00
EOY	**3**	**4699**	**0.64**

Summary Key Findings/Opportunities for Improvement:

We met our goal for day center falls during 2020. However, it should be noted that few participants were in the PACE Center due to the COVID-19 pandemic starting in late quarter 1. Beginning in quarter 3 of 2020, we began to track and monitor participants who fell at home and within the community. We examined various elements of each fall, such as where they occurred and the contributing factors. In 2021, we intend to change the quality element of "Falls in the Day Center" to "Falls at Home or in the Community" as this will more accurately reflect our efforts in ensuring participant safety. Several interventions have been discussed such as assessing the participant's home/community environment for barriers to safe movement/mobility. At the recommendation of our medical team, we initiated the *Fall Risk Assessment Tool* (FRAT) during Interdisciplinary Team meetings. This tool analyzed a participant's previous falls and examined predictors for future falls. Medications which may increase fall risk and cognition status are also reviewed. The FRAT is very similar to the root cause analysis which the QI Team facilitates for each injury resulting fall.

QI20.12 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <35.73%

Goal: Met

Data/Analysis: The 2020 rate was 30%.

DDE: Dementia + Tricyclic Antidepressant or Anticholinergic Agents					
	2019 Medicare Quality Compass				
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
30%	44.44 %	40%	35.73%	33.96%	**33.96%**

Summary and Key Findings/Opportunities for Improvement:

In 2020, 30% of our participants who were diagnosed with dementia, were prescribed a tricyclic antidepressant or anticholinergic agent. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed the cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered "red flags" per CMS and Beer's criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile.

QI20.13 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Non-aspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.90%

Goal: Met

Data/Analysis: The 2020 rate was 2.7%.

DDE: CKD+ Non-aspirin NSAIDS or Cox2 Selective NSAIDs				
	2019 Medicare Quality Compass			
MY 2020 PACE	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
2.7%	9.31%	6.36%	3.90%	**2.47%**

Summary and Key Findings/Opportunities for Improvement:

Careful review of participants with chronic kidney disease who are prescribed NSAIDS is an important factor in limiting the progression of kidney disease. Our in-house clinical pharmacist is a vital asset in monitoring potential drug/disease interactions and presenting therapeutic alternatives to the medical provider. The continued coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results are comparable to the 2019 Medicare HEDIS Quality Compass 90th percentile.

QI20.14 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 120mg

Goal: 100% of participants receiving opioids for 15 or more days at an average MME 120mg will be reevaluated monthly by their treating provider.

Goal: Not Met

Data/Analysis: The 2020 rate was 57% (4 out of 7 participants were reevaluated monthly)

Quarter 2020	# Participants with High Dosage of Opioids
Q1	1 out of 2 participants reevaluated (50%)
Q2	0 out of 2 participants reevaluated (0%)
Q3	1 out of 1 participant reevaluated (100%)
Q4	2 out of 2 participants reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

In the first and second quarters of 2020, we had challenges in meeting our goal; however, an aggressive and pro-active effort was implemented in response. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing.

During the latter part of quarter 2, a template was developed and then integrated into our EMR. This template prompts the medical provider to address key points in prescribing opioids and engage the participant in a discussion around narcotic use. The PACE QI department generates a monthly report of participants who are prescribed higher opioid doses and this list is shared with the medical team. These specific participants are then automatically added onto the provider's monthly schedule so that appropriate participant/PCP follow-up can occur. Discussions around prescribing opioids is a recurring agenda item on weekly provider meetings, thereby enhancing provider education. We will continue to track and monitor this in 2021 and anticipate that with the newly implemented template, we will achieve 100% in 2021.

QI20.15 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2020

Goal: Met

Data/Analysis: 99% of participants had medications reconciled within 30 days post discharge in 2020.

Medication Reconciliation Post-Discharge	Q1 2020	Q2 2020	Q3 2020	Q4 2020	EOY
Total # of Discharges	45	28	37	35	**145**
Received Reconciliation	44	28	37	35	**144**
Rate	**98%**	**100%**	**100%**	**100%**	**99%**
Goal	**90%**	**90%**	**90%**	**90%**	**90%**

Medication Reconciliation Post-Discharge				
	2019 Medicare Quality Compass			
MY 2020 PACE	25th Percentile	50th Percentile	75th Percentile	**90th Percentile**
99%	36.83%	46.16%	59.74%	**71.43%**

Medication Reconciliation Post-Discharge					
	2020 Star Rating Measure Cut Points				
MY 2020 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
99%	<48%	48% to 62%	62% to 71%	71% to 84%	**≥ 84%**

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center and provides us with our hospitalists and nursing home physicians. In 2019, the contract with House Calls Medical Associates extended to the provision of PCPs within the PACE clinic. Through this partnership, our providers maintain a close relationship with our participants and can take care of our participants across all levels of care thereby improving continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge. Our clinical pharmacist also plays a vital part in the reconciliation process as well as a dedicated additional clinical staff member who handles medication reconciliation for hospital and SNF discharges. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile.

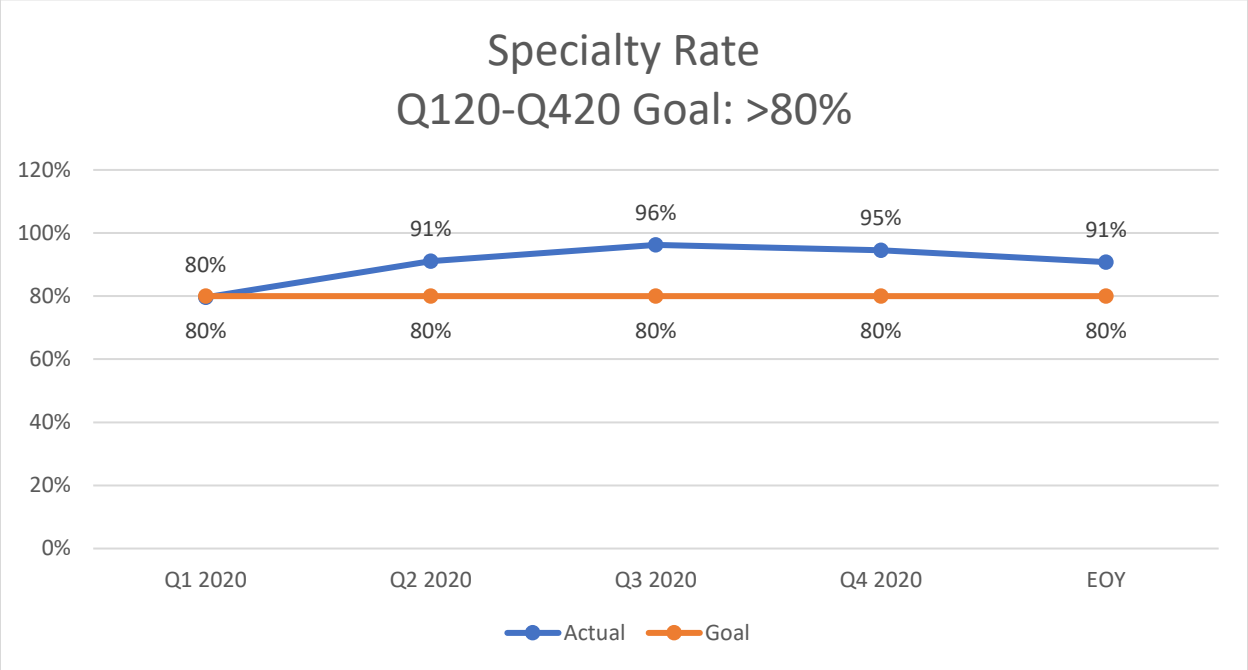
Access and Availability

QI20.16 Improve access to specialty practitioners

Goal: ≥ 80% of specialty care authorizations will be scheduled within 10 business days in 2020

Goal: Met

Data/Analysis: The 2020 rate was 91%.



Summary and Key Findings/Opportunities for Improvement:

This past year, we re-structured some activities associated with our clinic services. One area of redesign was the expansion of staff dedicated to scheduling specialty appointments. This task is rather complex in that the staff member not only schedules the appointment for the participant, but also handles appointment confirmation, coordinating transportation needs, and submitting relevant medical records to the specialist. Additionally, we now have a scheduler who is assigned to each of our 5 IDT teams and focuses on coordinating all these activities.

Pre-pandemic, we continued to have an optometrist and dentist on-site as well as a nurse practitioner dedicated to primary care podiatry issues. This greatly enhanced specialty access, particularly for our diabetic participants. As part of our operational Work Plan for 2021, we will look to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider. Since we historically met our benchmarks in this element, we intend to move our 2021 benchmark from ≥80% to ≥ 84% of specialty appointments scheduled within 10 business days.

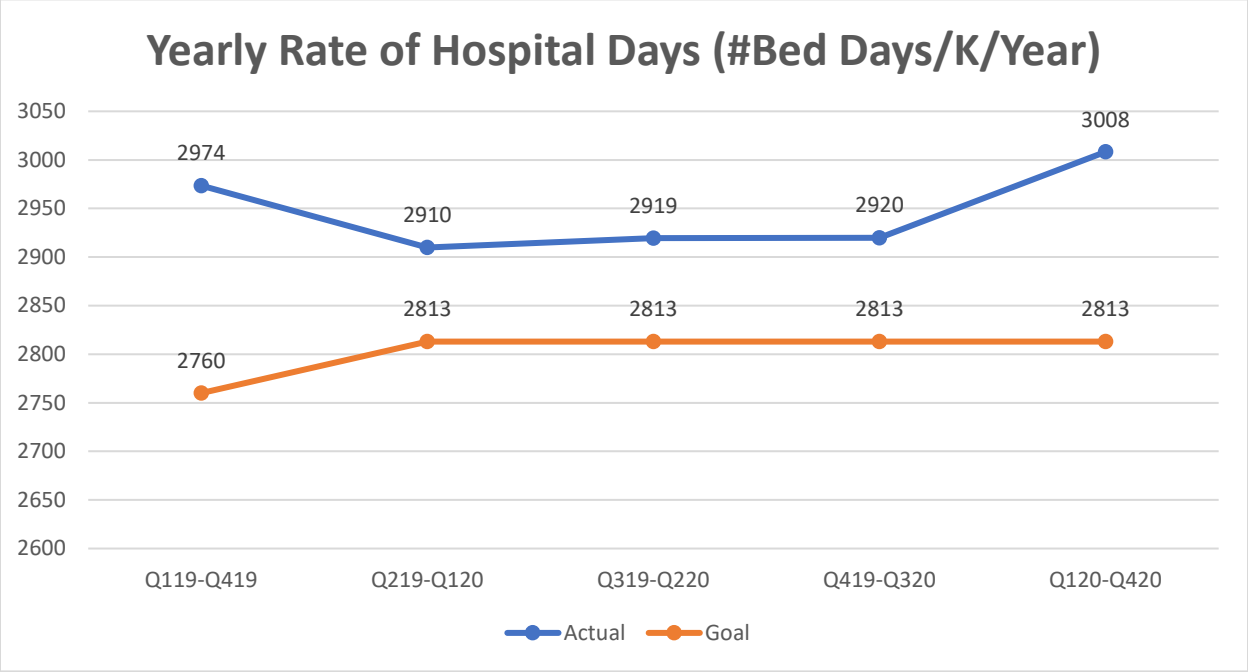
Utilization Management

QI20.17 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,813 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2020 rate was 3,008 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

COVID-19 had a significant impact on our hospitalizations. Our hospital utilization numbers increase over the course of the year, spiking in Q4. The majority of the admissions were for COVID-19 related issues, followed by complications with end stage renal disease and pneumonia.

PACE participants are high risk for being exposed to COVID-19 since many tend to live in crowded living situations and cannot easily be quarantined from others in the home. The majority of PACE participants who were infected with COVID-19, acquired the virus at home. The second highest means of infection occurred in participants who lived in nursing facilities. Initially, one of our strategies in reducing the rate of community acquired transmission was to house the susceptible (i.e. a member of their household tested positive) in a motel. However, this became increasingly difficult to carry-out. The rising COVID-19 infection rates among our patient combined with their comorbidities led to increased rates of hospitalization in 2020.

However, PACE was able to implement strategies aimed at reducing hospitalization of COVID-19 positive participants including:

1. COVID-19 positive participants were contacted on a daily basis for 10 days by their PCP.
2. Pulse oximeters and blood pressure machines were delivered to compromised participants and clinic nurses followed up as needed.
3. Implementation of a telehealth platform to allow participants to virtually engage with PACE providers and staff.

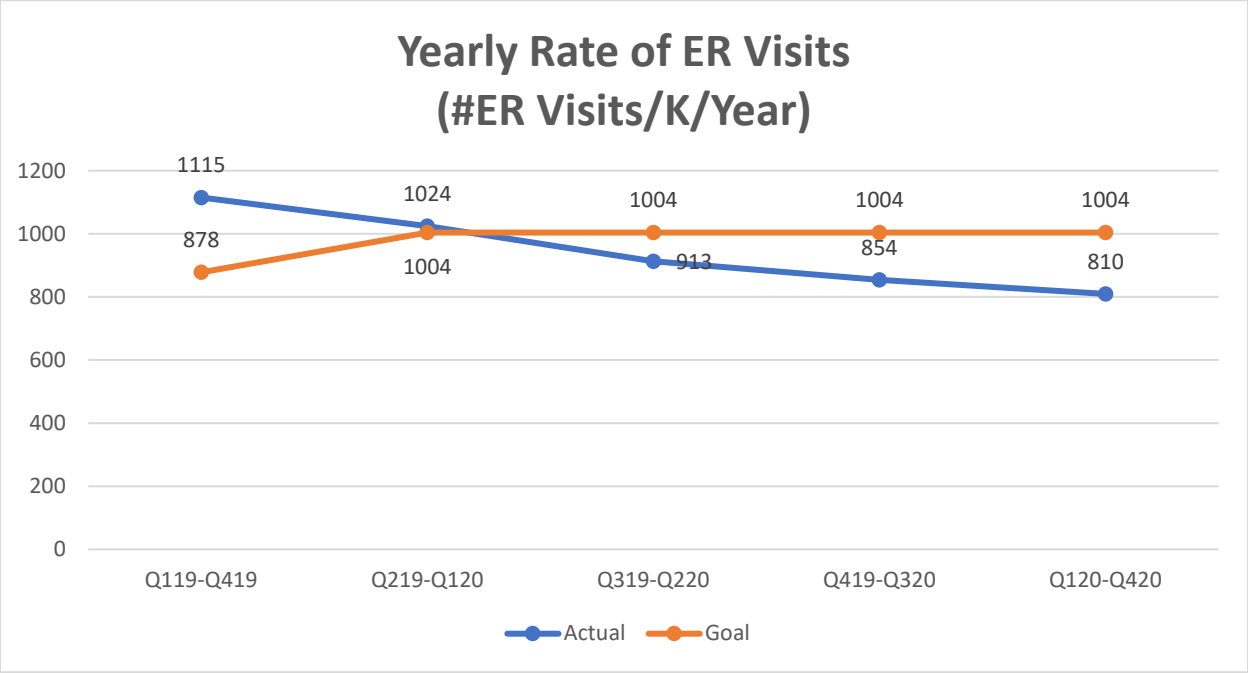
We will continue to monitor our hospital utilization and seek strategies to reduce our numbers in 2021.

QI20.18 Reduce the rate of ER utilization by PACE participants

Goal: < 1,004 emergency room visits per 1000 per year

Goal: Met

Data/Analysis: The 2020 rate was 810 emergency room only visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

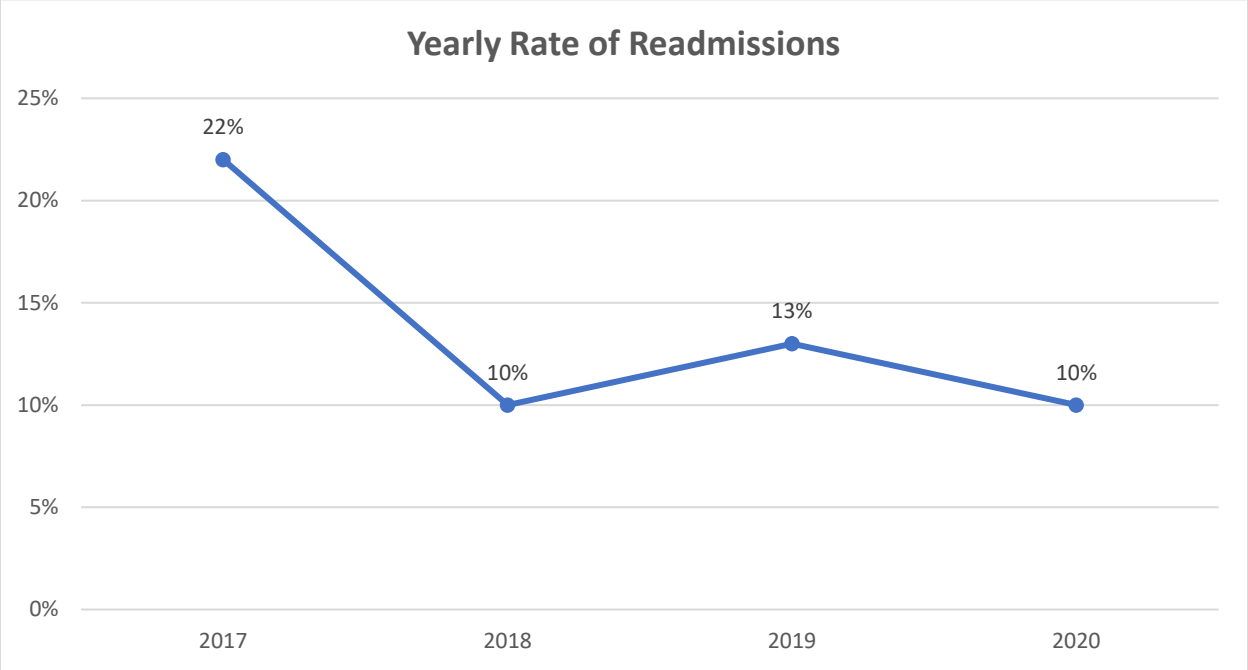
Emergency rooms visits declined throughout the year. Participants became apprehensive about going to the emergency room and risking further exposure to the COVID-19 virus and PACE was communicating with participants regularly through the daily wellness calls ensuring that all medical issues were being addressed in a timely manner and not ignored. We saw an increase in the utilization of our 24-hour on-call physician services, telehealth visits and home visits. Now, with the permanent integration of a telehealth platform into our clinical operations and a reliable and consistent after-hours call service, we hope that the emergency room utilization will continue to trend down even after the pandemic subsides. Our end of the year rate fell below our benchmark and demonstrated a 27% decrease in emergency room utilization from 2019.

QI20.19 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 15% 30-day all cause readmissions

Goal: Met

Data/Analysis: The 2020 rate was 10%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year over year due to the small total number of participants and readmissions. We ended 2020 with a 10% 30-day readmission rate which is a 3% decrease from 2019. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2020, we began incorporating the morning clinical huddles into the interdisciplinary team meetings (IDT). This concept was piloted in Q4 of 2019 with one IDT with great success and was adopted program wide in 2020. Additionally, important measures taken by PACE PCPs aided in our ability to meet our goal to reduce 30-day hospital readmissions. PCPs utilized telehealth to triage participants health needs before they required emergency services, such as following up on wellness calls as necessary and providing telemedicine services though the afterhours clinic line. PCPs also followed up with participants soon after their hospital discharge in order to reassess the participants immediate health needs following hospitalization, as well as any long-term need for changes in care plan to prevent future hospitalizations.

QI20.20 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 3% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: 2020 rate was 1.7% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

One of the main goals of the PACE program is to help our participants continue to live safely at home for as long as possible. We ended the year with 1.7% of our participants who resided in an LTC. This is a slight increase from the 1.3% rate in 2019 but compares favorably to the CalPACE average of all California PACE programs of 3%. However, this is an area that we are monitoring closely as we expect we may see an increase in the upcoming years. There are several issues that are contributing to the rise in PACE LTC census for our high-risk participants, especially for those

with multiple advanced chronic conditions. These are participants whose outpatient management has been unsuccessful in the home, assisted living facility (ALF) or board and care (B&C) environment. Families and caregivers may be unable or unwilling to assist with necessary care tasks at home. Poor family support and fragile living environments can lead to increased ER and hospital utilization. On some occasions, participants need temporary placement in an LTC as a custodial care measure. These are participants with complex medical conditions that require complicated workups, specialty care, and who have difficulty with maintaining their care plan on their own at home. For example, participants who are noncompliant with their prescribed medications, refuse to attend their hemodialysis sessions, or have recurrent falls where all other fall prevention measures have failed. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. Although the number of participants residing in LTC facilities is approximately 1.7%, we recognize that as our program matures, we may see an increase in this percentage.

Enrollment

QI20.21 The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%

Goal: The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%

Goal: Not Met

Data/Analysis: We had 6 controllable disenrollments within 90 days which was 6.98% of the total disenrollment (86 total disenrollments in 2020)

Summary and Key Findings/Opportunities for Improvement:

In 2020, we did not meet our goal of less than 4% controllable disenrollments. Our controllable disenrollment rate for 2020 was 6.98%. We did, however, see a 3.71% improvement over 2019 when the controllable disenrollment rate was 10.71%. In 2020, 6 of our participants disenrolled for controllable reasons with the main reason of wanting to keep their pre-enrollment PCP and/or health plan. In effort to reduce these numbers, data related to disenrollment for controllable reasons is shared with the enrollment team throughout the year. This is done to ensure that the enrollment staff are communicating effectively with participants *prior* to their enrollment, so that participants fully understand the benefits and expectations of the PACE program when enrolling in PACE. In 2021, we will adjust our benchmark to a goal of less than 6.5% of participants disenrolling for controllable reasons. We will continue to monitor and share this information with staff to ensure continuous improvement.

QI20.22 Increase the Qualified Lead to Enrollment conversion rate to 55% in 2020

Goal: Increase the Qualified Lead to Enrollment conversion rate to 55% (5% improvement over baseline)

Goal: Met

Data/Analysis: Final rate was 67%.

Quarter 2020	Rate
Q1	59%

Q2	76%
Q3	64%
Q4	77%
EOY	**67%**

Summary and Key Findings/Opportunities for Improvement:

In 2020, we exceeded our goal in the percentage of qualified leads to enrollment. This afforded the frail and elderly in our community greater access to health care in an environment which also supports their physical, rehabilitative, and psychosocial needs.

Several strategies led to successful enrollment:

1. Revision of our screening, intake, and assessment tools to screen-out enrollees who were too high-functioning and would not be eligible per State certification, although they initiated an inquiry.
2. Utilization of data indicating origins of referrals to PACE.
3. Redesigned marketing collateral, which educated the community in the benefits of enrolling in PACE.

Transportation

QI20.23 and QI20.24: Transportation

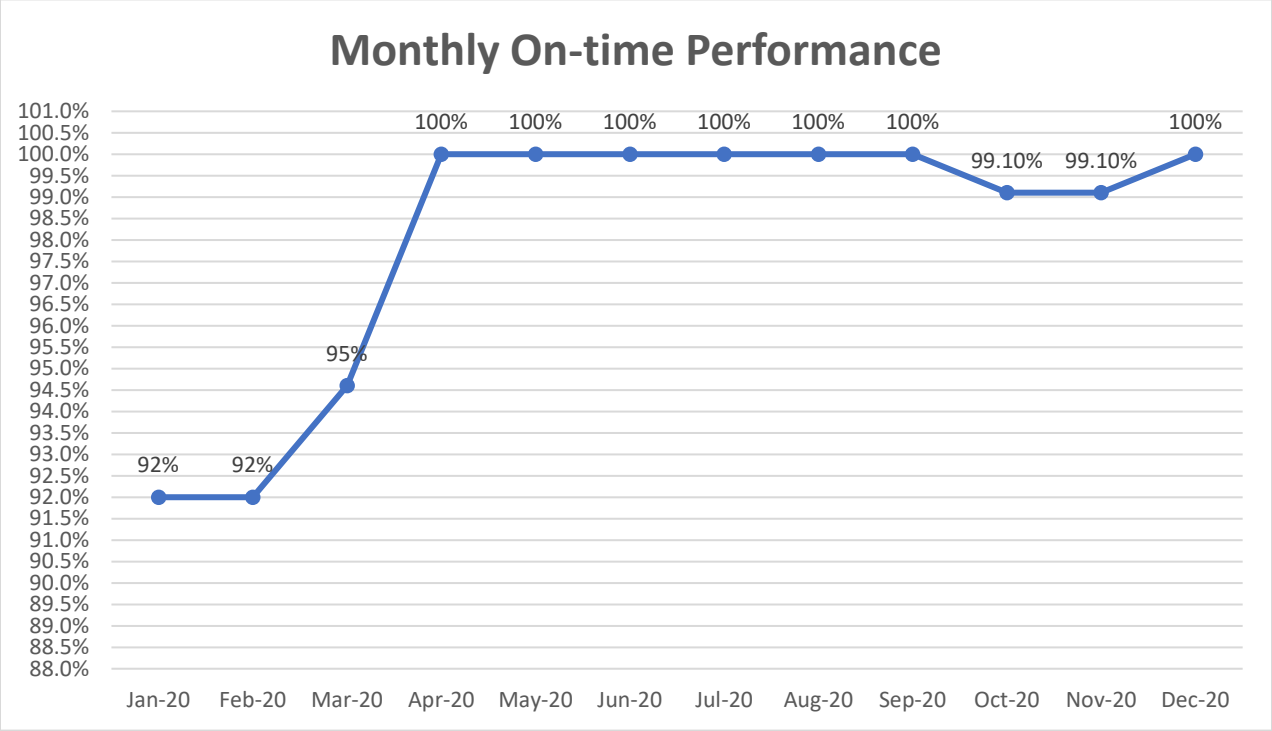
Goal: Ensure PACE transportation ride times are less than 60 minutes per trip with a goal of 0 trips > 60 minutes in duration, and improve participant experience by providing timely transportation services with a goal of ≥ 92% on-time performance.

Goal: Met

More than 60 minutes in ride duration: 0 trips
On-time performance: ≥ 92%

Data/Analysis: 2020 data

More than 60 minutes in ride duration: 0 trips
On-time performance: 98%



Summary and Key Findings/Opportunities for Improvement:

Significant operational changes within the transportation department occurred in March 2020:

1. A transportation coordinator was hired to improve efficiency/oversight and participant satisfaction.
2. A new in-house tracking system was implemented which monitored late trips and outside appointments which may have been extended, and any other delays. This system allowed for solutions to problems in real-time.
3. Comprehensive reports and meetings were held monthly to address concerns. These operational changes allowed us to meet our goals in on-time performance and maintaining trips under 60 minutes.

Prior to the onset of the pandemic, PACE transportation provided over 6,200 trips for our participants monthly. As we began to curtail day center attendance in mid-March and eliminate non-essential specialty appointments, the activities of our transportation department were realigned to meet the new needs of participants. For quarters 2–4, our transportation department redirected their efforts to other PACE related services such as providing transportation services for drive-through immunization and COVID-19 testing, delivery of care packages and durable medical equipment. Despite the decrease in transportation demands, April through December 2020 still averaged 2,070 monthly trips. For the year, transportation completed 35,967 one-way trips with an on-time performance of 98%. We will continue to actively monitor trends in transportation, not just in terms of on-time-performance, but also for participant satisfaction.

Meals

QI20.25 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 71% on Satisfaction with Meals summary score on the 2020 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 80% overall weighted participant satisfaction summary score.

2020 Participant Survey Satisfaction with Meals Domains

Domain	2019	2020	2020 National Average
Do the lunches look good?	75%	81%	69.5%
Do the lunches taste good?	72%	75%	61.9%
Do you get a variety of foods here?	85%	78%	81.1%
Meal satisfaction composite score	77%	78%	70.7%
Overall, would you rate the lunches as excellent, very good and/or good?	81%	**80%**	79.0%

Summary and Key Findings/Opportunities for Improvement:

In 2020, we met our benchmark with 80% of PACE participants indicating satisfaction with their meals, exceeding the PACE national average of 79%. In 2020, we engaged the services of a research entity which surveyed participant satisfaction for PACE programs statewide. One of the domains surveyed was a participant's satisfaction with meals. Survey responses indicated that participants were generally satisfied with meals provided by PACE. In 2019–2020, we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants. As the pandemic emerged in March 2020 and we no longer provided day center attendance, we began home delivered meals. For the months of April through December of 2020, we provided an average of more than 2,000 meals per month for a total of 32,785 in 2020.

Most participants indicated that the meals looked appealing, tasted good and were varied. Our dietary team monitored participant meals, frequently adjusting menus to be consistent with therapeutic diet parameters as well as an individual's preference. We will continue to monitor this domain in 2021.

Overall Satisfaction

QI20.26 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: Greater than or equal to 89% on the Overall Satisfaction Weighted Average on the 2020 PACE Satisfaction Survey.

Goal: Met

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

Participant Survey Overall Satisfaction Domains

Domain	2019	2020	2020 National Average
Would you recommend the program to a close friend or relative?	96%	91%	92.9%
Overall satisfaction with the care received	96%	88%	94.6%

2020 Participant Survey Domains

Domain	2019	2020	2020 National Averages
Transportation	96%	95%	94.0%
Center Aids	94%	96%	90.6%
Home Care	89%	90%	86.5%
Medical Care	93%	91%	90.7%
Health Care Specialist	98%	87%	89.7%
Social Worker	96%	93%	94.6%
Meals	77%	78%	70.7%
Rehabilitation Therapy and Exercise	98%	87%	93.3%
Recreational Therapy	91%	85%	80.1%
Environment and Safety	93%	85%	87.5%
Weighted Summary Score	92%	**89%**	88.3%

Summary and Key Findings/Opportunities for Improvement:

In fall 2020, CalOptima PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 111 participants via telephone, to gauge the participant's satisfaction with CalOptima PACE services. This is a standardized survey taken by most of the PACE programs in the country.

The overall satisfaction score was 89%, with 91% of our participants indicating they would recommend PACE to a close friend or relative. High marks were given to our center aides, transportation, medical team, home care, and social work departments. It does appear that the pandemic did impact our scores as this was a decrease from our score of 96% in 2019. We saw a decrease in scores in the areas whose face-to-face services were decreased during the pandemic including rehabilitation and exercise, recreational therapy, and the heath care specialist. We will look at additional ways to provide participants services as the pandemic continue. However, we

expect our scores to increase as participants are allowed to come back to the center and receive the services in the way they had prior to the pandemic.

SECTION 5: 2020 HEALTH PLAN MANAGEMENT SYSTEM (HMPS)

2020 HPMS Updates: In 2018, CMS implemented changes to the Level I event and Level II reporting structure. Level I and Level II events are now referred to as Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

1. Grievances
2. Appeals
3. Unusual Quality Incidents
4. Medication Errors
5. Immunizations (evaluated in the Quality of Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

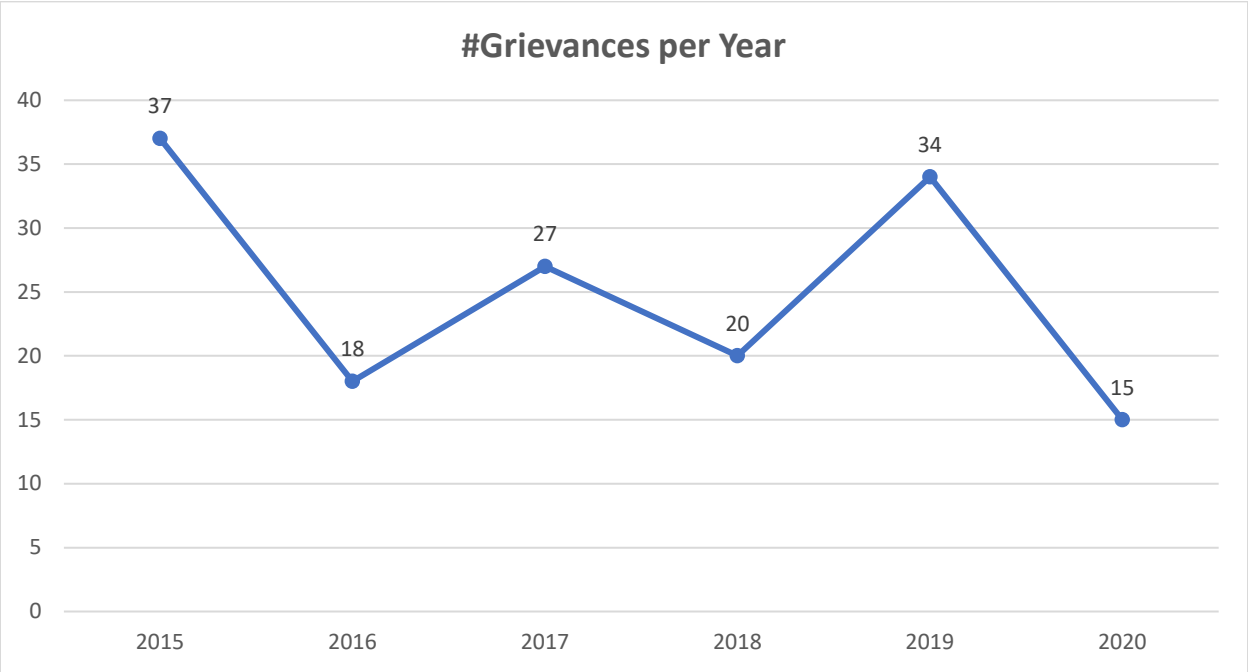
Grievances

Data Analysis:

Quarterly Grievances Q1 2019–Q4 2020

	CENTER							CLINIC			
					Transportation			Clinical Care/			
	# Grievance	Other	Food	Home Car	Timeliness	Prt-Driver	Escort	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q1 2019	2	0	0	0	1	0	0	0	0	1	0
Q2 2019	9	0	0	0	8	0	0	0	0	1	0
Q3 2019	14	7	0	0	4	0	1	0	0	0	2
Q4 2019	9	0	0	2	4	0	0	1	0	1	1
Q1 2020	4	1	0	0	2	0	1	0	0	0	0
Q2 2020	1	1	0	0	0	0	0	0	0	0	0
Q3 2020	2	0	0	0	0	0	0	1	0	1	0
Q4 2020	8	0	0	0	2	1	0	2	1	1	1

Grievances Per Year 2015–2020



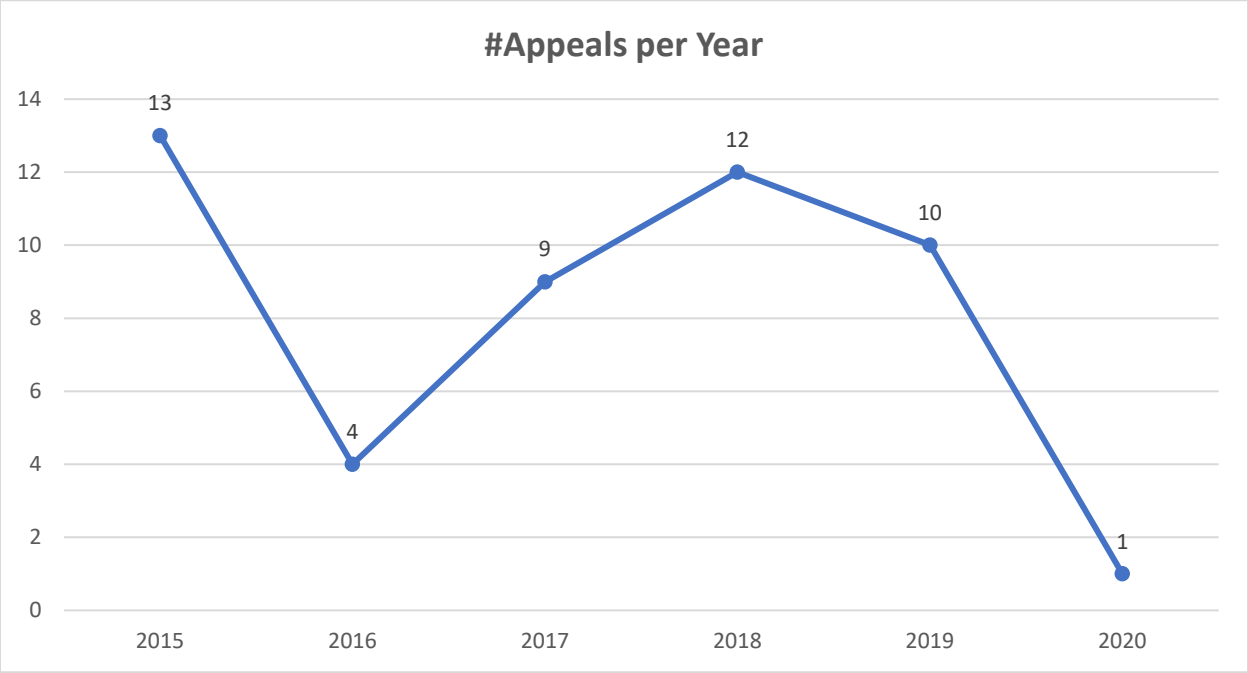
In 2020, we saw a 55% decrease in the number of grievances filed by participants. This is somewhat to be expected during the pandemic restrictions since participants were under stay-at-home orders. Most of the grievances were transportation related issues such as being picked up late or drivers arriving at the participant home too early. Despite this, our participant satisfaction survey revealed that 95% were satisfied with transportation services. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period.

The majority of participants filing grievances are satisfied with the resolutions. As with previous years, we will continue to monitor and observe for trends with grievances filed.

Appeals

Data Analysis:

Appeals Per Year 2015–2020

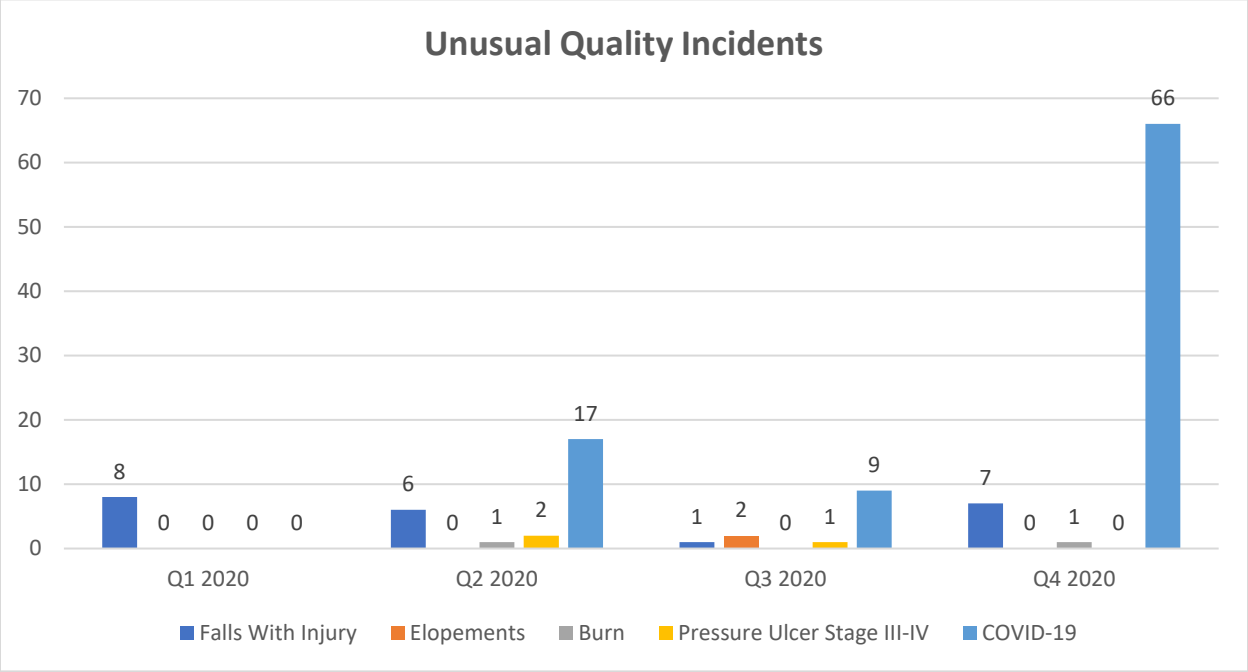


Appeals by participants continue to be minimal in 2020. Only 1 appeal was submitted in 2020 and a third-party review team upheld CalOptima PACE's IDT's decision. This is in part due to the time the team takes in explaining the reasons for denials to our participants and ensuring all their questions are answered.

Level II Events/Unusual Quality Incidents

Description of Level II Events: Unusual quality incidents (formerly referred to as Level II events) are monitored by the PACE QI team. Unusual quality events including falls with injury, elopements, burns, pressure ulcers (stage III–IV) and infectious disease outbreaks and are reported to CMS and DHCS on a quarterly basis. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All unusual quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed on each incident. The RCA begins with the QI team investigating the incident (what, where and when), followed by a meeting of appropriate disciplines such as nursing, social worker, rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented. In some instances, interventions could include systemic or operational failures that need remediation. In 2019, there was one quality incident which led to an operational change and in 2020, no quality incidents required an operational change.

Data Analysis: See graph below



Falls with injury are usually the most prevalent unusual quality event at PACE. As the stay-at-home orders were mandated, participants sustained more falls in their home, usually during transfers. The number of falls however did not increase significantly from 2019. As with the previous year, the falls are either a result of non-use of durable medical equipment or lack of family supervision. In 2020, due to the COVID-19 pandemic, we saw an increase in reporting of infectious disease cases under unusual quality incidents, especially in quarter 4. An RCA was conducted after each unusual quality incident.

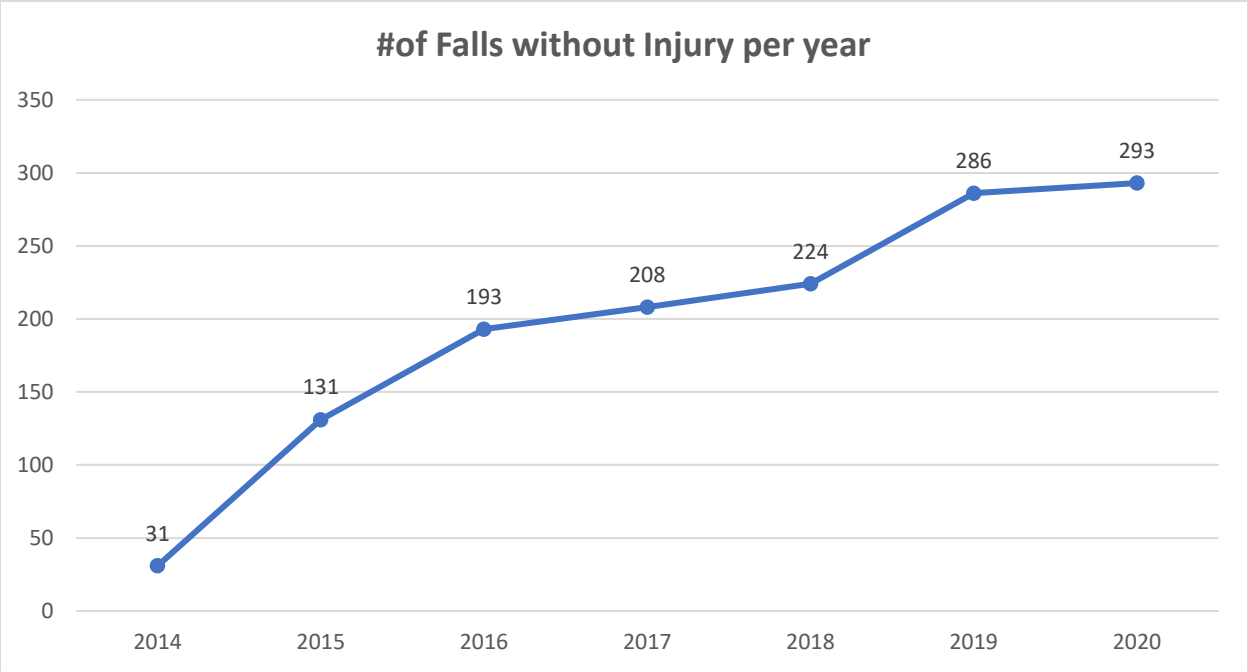
Medication Errors

A total of 3 medication errors were reported in 2020 which reflects a 50% decrease from the previous year. Two of the medication errors were attributable to staff errors and errors in transcription. In response to the staff errors, education and training were implemented. Another error was made by our contracted pharmacy. In this case, we requested a corrective action plan from the pharmacy, and they complied with this request. No further incidents have occurred.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2020



As in previous years, we have continued to maintain the low number of falls. In 2020, we saw a slight 2.4% increase from 2019 figures, however, this corresponds to the increase in membership. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal to decrease in the numbers of falls in 2020 and continuing into 2021. Ongoing falls prevention groups include:

1. *PACE Fall Committee*: Comprised of PACE rehabilitation staff which reviews those participants who have incurred a fall.

2. *PACE Fall Prevention*: Comprised of PACE participants who are educated by the rehabilitation staff in fall recovery mechanisms.

3. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the rehabilitation team to discuss safety in the home and environment.

4. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

In addition to the above, one of our clinic physicians adopted the Fall Risk Assessment Tool (FRAT) to be used during IDT meetings where participants with recurrent falls are discussed. This predictive tool analyzes risk factors for falls in the elderly population by assessing a participant's medication regimen, psychological status (depression, anxiety) and cognitive status (i.e. dementia). Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, collaborate to develop participant-specific strategies for fall prevention.

Denials of Prospective Enrollees

Two prospective enrollees were denied enrollment by the State.

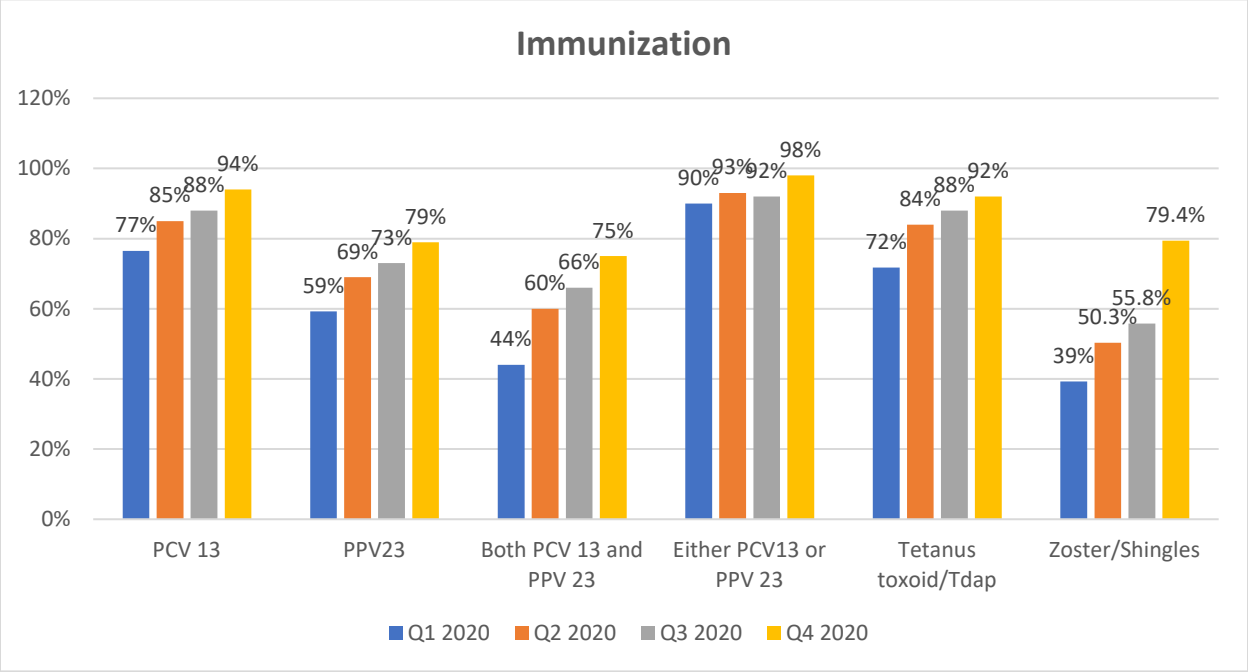
Quality Initiatives

In 2020, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes:

1. **Immunization Dashboard:** With a robust approach in disease prevention, the PACE clinical team rolled-out an aggressive immunization initiative, particularly for the Prevnar 13 and the Pneumococcal 23 vaccines. The elderly PACE population is at an increased risk of contracting pneumococcal disease and the disease itself is highly contagious among the elderly. Optimally, we would like to have participants vaccinated with both vaccines per CDC recommendation. The immunization initiative is a collaborative effort by the QI team and clinical operations.

   Monthly reports are generated by the QI team, specifying participants who require not only the pneumococcal vaccines, but the tetanus/diphtheria and shingles vaccine as well. This report also captures those participants who have refused the vaccines in the past. The clinical director receives these reports and distributes them to the medical providers who are responsible for participants who are assigned to their team. Participants are then called and scheduled for vaccine administration either within the clinic or through our drive-in immunization services. Participants who continue to refuse the vaccines are scheduled for an appointment with their PCP at which time the physician will discuss the importance of the immunization as a part of overall health goals.

   The graph below illustrates our achievements in vaccinating our participants throughout 2020. In respect to vaccinating with both pneumococcal vaccines, our efforts showed a 31-percentage point increase over the 4 quarters of 2020. Other vaccines such as the shingles and Tdap vaccines also showed significant successes in vaccination rates. We will continue with this initiative in 2021.



2. **Advance Health Care Directive:** Provided participants the opportunity to complete an advance health care directive, thereby designating a medical decision-maker in the event that the participant is unable/incapacitated to make such a decision. From the months of June through November of 2020 we reached out to participants and educated them on the purpose of the advance health care directive and upon request, provided assistance to complete the directive. We offered notary services, and PACE transportation was provided to center so that social workers could answer participant's questions. The original documents were provided to the participant and a copy was uploaded into their medical record. Prior to the implementation of the initiative, only 15% of the participants had an advance health care directive or a durable power of attorney. Post-initiative, 39% of the participants have a notarized advance health care directive.

   Looking forward into 2021, we intend to offer this service at the time of enrollment into the PACE program.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2021

1. **Improve the Quality of Care (QOC) for Participants**
   a. Addition of new COVID-19 immunization element to ensure all participants get vaccinated.
   b. Continue to expand telehealth services, drive through clinics, and home visits.
   c. Refine new clinical triage workflow.
   d. Further develop the operational/utilization dashboard to reflect the oversight needed as PACE expands ACS partners.

2. **Ensure the Safety of Clinical Care**
   a. The QI team will continue to focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board

and care facilities and transportation.

b. The grievances and potential quality issues involving downstream vendors will continue to be tracked and trended to assure no service or clinical trend is emerges.
c. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.

3. **Ensure the Appropriate Use of Resources**
    a. Inpatient/ER Utilization
        i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk dialysis participants.
        ii. Continue to refine the ER Diversion program.
    b. Specialty Care
        i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care, and attend some IDT meetings.
        ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
    c. Staffing
        i. Continue refinement of the staff relative value units (RVUs) to monitor staff productivity.

4. **Improve Participant Experience**
    a. Participants will be updated on the satisfaction survey process.
    b. The PACE QI team will survey a sample of participants semi-annually and use the metrics as a lead indicator and help find opportunities for improvement.
    c. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.
    d. Once participants return to the PACE day center, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.
    e. Increase the number of participants who have a completed advanced health care directed.

5. **Ensure Appropriate Access and Availability**
    a. Expanding the number of ACS sites will continue to be considered in 2021.
    b. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care, and attend occasional interdisciplinary care team meetings.
    c. Bring back specialists back into the clinic once the pandemic ends.

SUMMARY

CalOptima PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to

live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

APPENDIX: 2020 PACE QI EVALUATION

PACE

CalOptima

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2020 PACE Quality Improvement Plan Evaluation

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021

Miles Masatsugu, M.D.
Medical Director

Back to Agenda

2020 PACE Accomplishments

- Swiftly responded to the COVID-19 pandemic by quickly implementing “PACE without Walls”
- Redesigned the triage and clinical workflows to respond to pandemic
- Only 1.7% of participants resided in Long-Term Care
- 98% pneumococcal immunization rate
- 93% influenza immunization rate
- Quality of Diabetes Care
  - 98% had annual eye exam completed
  - 100% had nephropathy monitoring
  - 87% had blood pressure controlled

2020 PACE Accomplishments

- 99% medication reconciliation rate following a hospital discharge
- 94% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Transportation with over 35,000 one-way trips with an on-time performance of 98%
- Overall score of 89% compared to national average of 88%
- Met 21 of 26 work plan element goals

PACE Membership Growth 2013-2020

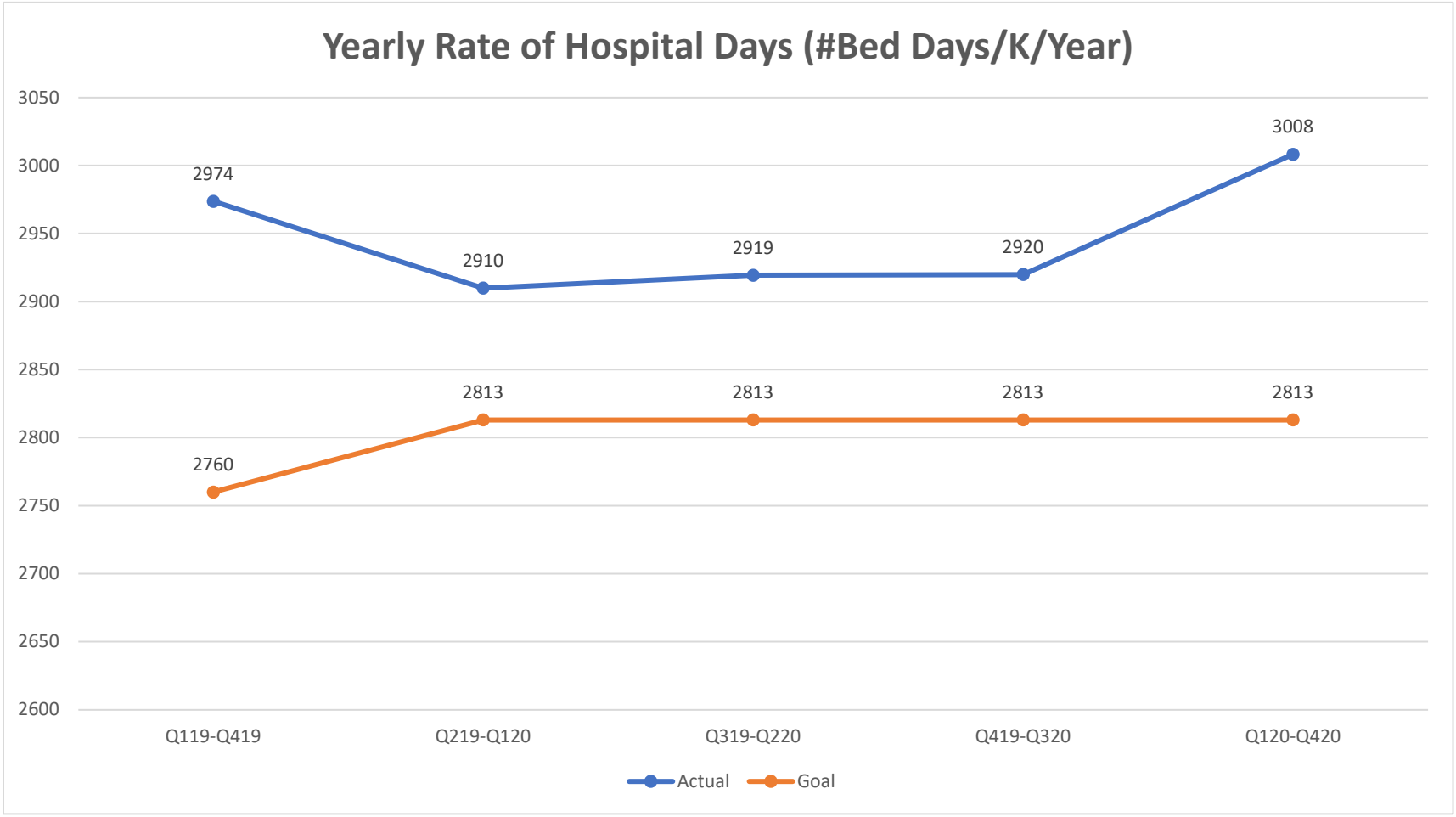
Elements 8-10: Comprehensive Diabetes Care

Higher Is Better		Medicare Quality Compass 2019 HEDIS Percentiles			
Domain	**2020 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	95th Percentile
Annual Diabetic Exams	**98%**	75.28%	82%	85.33%	**87.10%**
Nephropathy Monitoring	**100%**	95.95%	97.08%	98.30%	**98.78%**
Blood Pressure Control	**87%**	69.53%	76.56%	81.50%	**84.91%**

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

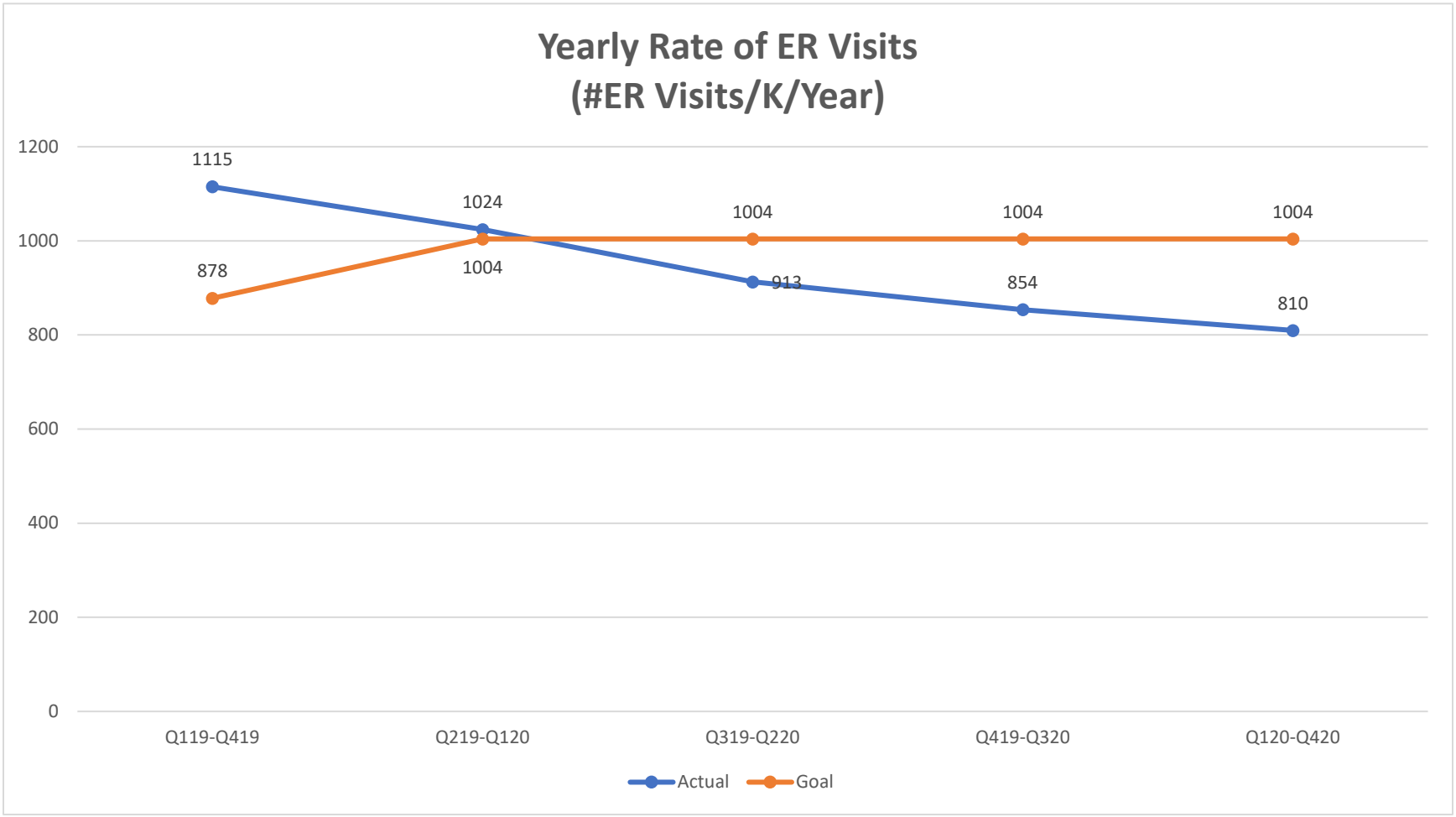
Lower Is Better		Medicare Quality Compass 2019 HEDIS Percentiles			
Domain	**2020 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	95th Percentile
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**30%**	44.44%	40%	35.73	**33.96%**
Chronic Renal Failure + NSAID	**2.7%**	9.31%	6.36%	**3.90%**	2.47%

Element 17: Hospital Bed Days (Goal: <2813 Bed Days/K/Year)



Back to Agenda

Element 18: ER Visits (Goal: <1004 ER Visits/K/Year)



Back to Agenda

Element 25: Annual Participant Satisfaction Survey Results (Goal: 88% on Overall Weighted Score)

Domain	2019 CalOptima PACE	2020 CalOptima PACE	2020 National PACE Average
Transportation	96%	**95%**	**94%**
Center Aids	94%	**96%**	**90%**
Home Care	89%	**90%**	**86%**
Medical Care	93%	**91%**	**90%**
Health Care Specialist	98%	**87%**	**89%**
Social Worker	96%	**93%**	**94%**
Meals	77%	**78%**	**70%**
Rehabilitation Therapy and Exercise	98%	**87%**	**93%**
Recreational Therapy	91%	**85%**	**80%**
Environment and Safety	93%	**85%**	**87%**
Overall Weighted Score	92%	**89%**	**88%**

* Decrease from 2018. Will improve score in 2020.

Back to Agenda

Opportunities for Improvement in 2021

- Quality and Safety of Clinical Care
  - Add COVID-19 related quality initiatives and work plan elements in 2021 including COVID-19 vaccine adherence
  - Monitor participants receiving more than an average milligram morphine equivalent (MME) dose of 90mg
- Ensure Appropriate Access and Availability
  - Continue expansion of the PACE telehealth program
  - Possible reopening of the PACE day center
- Ensure the Appropriate Use of Resources
  - Refine the Emergency Room Diversion program
  - Increase the number of PACE core specialists willing to work closely with the PACE program
- Improve Participant Experience
  - Refine “PACE without Walls”

2020 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI20.01	Improve the Quality of Care for Participants	**2019 PACE QAPI Plan and Work Plan Annual Evaluation**	2019 PACE QAPI Plan will be evaluated by March 1st, 2020	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2020	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QI20.02	Improve the Quality of Care for Participants	**2020 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2020	QI Planand QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2020	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QI20.03	Improve the Quality of Care for Participants	**Influenza Immunization Rates**	>/= 94% of eligible participants will have their annual influenza vaccination by December 31st, 2020	Improve compliance with influenza immunization recommendations	Q3 and Q4 2020	12/31/2020	PACE Clinical Operations Manager	90%	Not Met	N/A	N/A	N/A	N/A	93%	Not Met	93%	Not Met
QI20.04	Improve the Quality of Care for Participants	**Pneumococcal Immunization Rates**	>/= 94% of eligible participants will have had their pneumococcal vaccination by December 31st, 2020	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2020	PACE Clinical Operations Manager	90%	Not Met	93%	Not Met	94%	Met	98%	Met	98%	Met
QI20.05	Improve the Quality of Care for Participants	**Infection Control**	In 2020, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2020	PACE Clinical Operations Manager	2.21	Met	1.17	Met	0.52	Met	2.24	Met	1.55	Met
QI20.06	Improve the Quality of Care for Participants	**Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment**	>/=95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2020	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2020	PACE Center Manager	99%	Met	95%	Met	94%	Not Met	90%	Not Met	94%	Not Met
QI20.07	Improve the Quality of Care for Participants	**Care for Older Adults (COA): Functional Status Assessment**	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2020	PACE Center Manager	100%	Not Met	100%	Met	100%	Met	100%	Met	100%	Met
QI20.08	Improve the Quality of Care for Participants	**Diabetes Care**	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director	72%	Not Met	74%	Not Met	84%	Met	87%	Met	87%	Met
QI20.09	Improve the Quality of Care for Participants	**Diabetes Care**	> 85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020		96%	Met	97%	Met	99%	Met	98%	Met	98%	Met
QI20.10	Improve the Quality of Care for Participants	**Diabetes Care**	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020		99%	Met	100%	Met	100%	Met	100%	Met	100%	Met

Back to Agenda

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI20.11	Ensure the Safety of Clinical Care	Day Center Falls	<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE)	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2020	PACE Center Manager	2.52	Met	0	Met	0	Met	0	Met	0.64	Met
QI20.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director	18%	Met	22%	Met	29%	Met	30%	Met	30%	Met
QI20.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director	0%	Met	2.6%	Met	2.7%	Met	2.7%	Met	2.7%	Met'
QI20.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2020	The PACE QI Department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2020	PACE Clinical Medical Director	1out of 2 had f/u (50%)	Not Met	0 out of 2 had f/u (0%)	Not Met	1 out of 1 had f/u (100%)	Met	2 out of 2 had f/u (100%)	Met	4 out of 7 had f/u (57%)	Not Met
QI20.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	>/=90% of participants will have their medications reconciled within 30 days of hospital discharge in 2020	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2020	PACE Pharmacist	98%	Not Met	100%	Met	100%	Met	100%	Met	99%	Met
QI20.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	>/= 80% of specialty care authorizations will be scheduled within 10 business days in 2020 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2020	PACE Clinical Operations Manager	80%	Met	91%	Met	96%	Met	95%	Met	91%	Met
QI20.17	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	< 2,813 hospital days per 1000 per year (5% decrease from 2019)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director	2910	Not Met	2919	Not Met	2920	Not Met	3008	Not Met	3008	Not Met
QI20.18	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	< 1,004 emergency room visits per 1000 per year (10% decrease from 2019)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director	1024	Not Met	913	Met	854	Met	810	Met	810	Met
QI20.19	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<15% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2020	PACE Medical Director	12%	Met	5%	Met	15%	Met	6%	Met	10%	Met

Back to Agenda

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI20.20	Ensure Appropriate Use of Resources	Long Term Care Placement	<3% of members (July 2019 CalPACE average) will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Center Manager	2%	Met	2%	Met	2%	Met	1%	Met	1.7%	Met
QI20.21	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager	18%	Not Met	4%	Met	0%	Met	0%	Met	7%	Not Met
QI20.22	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 55% in 2020 (5% improvement over baseline)	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager	59%	Met	76%	Met	64%	Met	77%	Met	67%	Met
QI20.23	Improve Participant Experience	Transportation	l00% of transportation trips will be less than 60 minutes in 2020	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2020	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI20.24	Improve Participant Experience	Transportation	>/= 92% of all transportation rides will be on-time in 2019	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure acurracy of reported times.	Quarterly	12/31/2020	PACE Center Manager	95%	Met	100%	Met	100%	Met	99.40%	Met	98%	Met
QI20.25	Improve Participant Experience	Increase Participant Satisfaction with Meals	>/= 71% on Satisfaction with Meals summary score (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2020	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	78%	Met
QI20.26	Improve Participant Experience	Increase Overall Participant Satisfaction	>/=89% on the Overall Satisfaction Weighted Average (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2020	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%	Met

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 25, 2021
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

6. Consider Recommending Board of Directors Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Contact

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887

Recommended Action

Recommend Board of Directors approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a Program of All-Inclusive Care for the Elderly (PACE) Provider on October 7, 2010. The CalOptima PACE program opened in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents. As of December 31, 2020, CalOptima PACE had 395 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.

Discussion

The 2021 CalOptima PACE QI Plan is based on CalOptima's seven full years of data collection, review and analysis with specific data driven goals and objectives. The COVID-19 pandemic had a significant impact on the program's operations in 2020 as its day center closed for most of the year to limit congregating of our high-risk population of participants. Although the PACE clinic remained open, PACE developed and implemented the "PACE without Walls" program, which provided most of the participants' services in their home. This allowed for the continuation of existing PACE care services outside the PACE facility, including nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services, and personal care services. This led to more than

Back to Agenda

20,000 daily wellness calls, nearly 33,000 home delivered meals and monthly care package deliveries. The clinic established drive-through immunization clinics, a new telehealth platform, and increased the number of home visits.

The Work Plan elements were developed based on the opportunities for QI that were revealed in the 2020 CalOptima PACE QI Plan Evaluation. Three new QI Work Plan goals were added for 2021. Two of the elements focus on COVID-19 related issues by monitoring the COVID-19 immunization rates and engagement in telehealth. The final new element is monitoring the completion of an advanced health care directive. In addition, two of the 2020 elements were modified. We expanded the falls element to include the falls that occur at home as our participants stopped coming to the day center during the pandemic, and we reduced the opioids at high dosage element to include those participants taking an average of 90 MME/day or more, rather than 120 MME/day. PACE added two new quality initiatives in 2021. The COVID-19 Vaccine Quality Initiative will focus on vaccine education and outreach as well as the coordination of vaccine distribution with a goal of getting at least 90% of eligible participants vaccinated by the end of March 2021. The Telehealth Expansion Quality Initiative will focus on accelerating the adoption and utilization of telehealth services by our PACE participants. This will involve education, training and ensuring our participants have the hardware necessary to access our telehealth platform. Overall, the number of Work Plan elements increased from 26 to 29 in 2021. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommended action to approve the 2021 CalOptima PACE QI Plan does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-–22 Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a QI program. Through the Code of Federal Regulations (CFR), 42 CFR section 460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE organizations to have their QI Plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR section 460.132(a) and (b), the PACE organization leadership presents their QI Plan and any revisions to their governing body for annual approval to ensure effective organizational oversight. CMS and the state will review the plan during subsequent monitoring visits.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Proposed 2021 CalOptima PACE Quality Improvement Plan Description
2. PowerPoint Presentation – 2021 PACE QI Plan Description
3. Appendix A — Proposed 2021 CalOptima PACE QI Work Plan

/s/ Richard Sanchez *02/17/2021*
Authorized Signature **Date**

Back to Agenda

CalOptima Program All-Inclusive Care for the Elderly (PACE)

2021

Quality Improvement Plan Description

Back to Agenda Back to Item

PACE CalOptima
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SIGNATURE PAGE

PACE Quality Improvement Subcommittee Chairperson:

Miles Masatsugu, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, M.D. **Date**

Board of Directors Chairperson:

Andrew Do **Date**
Supervisor, First District

Table of Contents

INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QI Plan is developed by the PACE QI Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for QI and will drive appropriate additions or revisions in the QI Plan and to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.
    - Ensure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant experience.**
    - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
    - Provide education to staff on the multiple dimensions of patient experience.
    - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directive which honors members' wishes as well as advance directive rights.

- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions to identify high-risk members and opportunities for improvement.
    - Review documentation and coordination of care for participants receiving care in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.

- **Ensure the safety of clinical care**
    - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for QI.
    - Monitor and track falls occurring in the PACE day center and in the home and within the community.
    - Monitor and track the use of opioids at high dosages.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of care are met.

- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
    - Monitor and analyze access to specialty care
    - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

The CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's QI Committee (QIC) described in CalOptima's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible for allocating operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE QI Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once per quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that has been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director, who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director, or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director, or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance goals are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that may indicate significant over/under utilization.

Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE

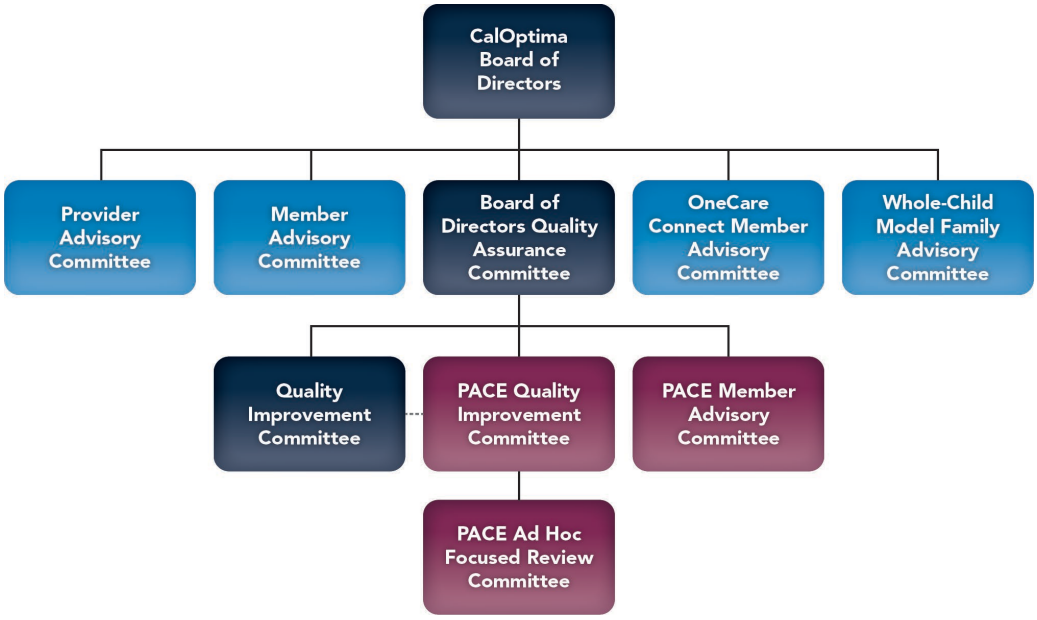
Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
PMAC provides recommendations to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to PMAC membership is disseminated through announcements at the PACE day center floor and all interested participants are invited to join, but must contact their social worker to be placed on the committee. The PACE Quality Improvement Department maintains a roster of active PMAC committee members. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence. PMAC meets on a quarterly basis.

2021Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
    - Hospital Bed Days
    - ER Visits
    - 30-Day All-Cause Readmissions
    - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.
- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant HPMS Data

- Unusual Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan goalss which include:
    - Influenza and Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2021
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2021
    - Infection Control: Respiratory Infection Rates
    - Advanced Health Care Planning: POLST Completion
    - Advance Health Care Planning: Advanced Health Care Directive Completion
    - Functional Status Assessment Completion
    - Day center falls and falls occurring in the participant home or within the community

- Opioids at High Dosage Monitoring
- Medication Reconciliation Post Discharge
- Diabetes Care: Annual Eye Exams
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Enrolled for at least six months during measurement year
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
            - Participants who are 76 years and older as of December 31, 2021
- Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Enrolled for at least six months during 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
            - Participants who are 76 years and older as of December 31, 2021
            - Participants with End Stage Renal Disease
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
            - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Non-aspirin NSAIDS or Cox2 Selective NSAIDs
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI department for investigation, tracking, trending, and data gathering. These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals will be forwarded to the PACE QI department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.
- Telehealth will continue to be integrated as a modality to expand access to care.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with periodic ride-alongs. The times gathered during the ride-alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through periodic participant meal satisfaction surveys as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Potential impact on participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and state administering agencies to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances

- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS), as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture, or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - Any elopement.
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
    - COVID-19 infections
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a CAP will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc., will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's two quality initiatives in 2021 are in response to the COVID-19 pandemic.
    - COVID-19 Vaccine Quality Initiative.
        - This initiative will focus on vaccine education, outreach, and vaccine distribution coordination.
    - Telehealth Engagement Quality Initiative
        - This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX: 2021 PACE QI WORK PLAN

PACE

CalOptima

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2021 PACE Quality Improvement Plan Description

Board of Directors' Special Quality Assurance Committee Meeting

February 25, 2021

Miles Masatsugu, M.D.

Medical Director

2021 PACE Quality Improvement (QI) Plan Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations
- Updates to address the COVID-19 pandemic including the two new 2021 quality initiatives

2021 PACE QI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience
- Additional Focus on COVID-19

2021 PACE QI Eliminated/Modified Work Plan Elements

- Added 3 elements
  - COVID-19 Immunization Rates
  - Advanced Care Planning: Advance Health Care Directive
  - Improve Access to Care: Engagement in Telehealth
- Modify two elements
  - Expanded the falls element to include those occurring at home
  - Reduced Opioids at High Dosage to include those participants taking an average of 90 MME/day
- Total of 29 QI Work Plan Elements in 2021

2021 Quality Initiatives

- COVID-19 Vaccine Quality Initiative
- Telehealth Engagement Quality Initiative

Recommended Action

- Recommend Board of Directors Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan Description

CalOptima's Mission

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


A Public Agency
CalOptima
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Medi-Cal
A Public Agency
CalOptima
Better. Together.


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


PACE
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2021 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.01	Improve the Quality of Care for Participants	2020 PACE QAPI Plan and Work Plan Annual Evaluation	2020 PACE QAPI Plan will be evaluated by March 1st, 2021	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
QI21.02	Improve the Quality of Care for Participants	2021 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2021	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
QI21.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2021	Improve compliance with influenza immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Q3 and Q4 2021	12/31/2021	PACE Clinical Operations Manager										
QI21.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2021	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥80% of eligible participants will have had their COVID-19 vaccination by December 31st, 2021	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.06	Improve the Quality of Care for Participants	Infection Control	In 2021, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.07	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2021	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2021	PACE Center Manager										
QI21.08	Improve the Quality of Care for Participants	Advanced Care Planning: Advance Health Care Directive	≥40% of participants will have an Advanced Health Care Directive in place by December 31st, 2021	Ensure all PACE members are offered assistance with the completion of the Advance Health Care Directive	Quarterly	12/31/2021	PACE Center Manager										
QI21.09	Improve the Quality of Care for Participants	Care for Older Adults (COA): Functional Status Assessment	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months. Exclusion: Participants in unstable condition due to a hospitalization. Assessment to be completed upon participant discharge.	Quarterly	12/31/2021	PACE Center Manager									100%	Met
QI21.10	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.11	Improve the Quality of Care for Participants	Diabetes Care	>85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.12	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.13	Ensure the Safety of Clinical Care	Falls at Home or in the PACE Day Center	<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE) ≥17% of participants will not experience a recurring fall within the same quarter	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement. Falls occurring in the home or community will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2021	PACE Center Manager										
QI21.14	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.15	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.16	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2021.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2021	PACE Clinical Medical Director										
QI21.17	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 30 days of hospital discharge in 2021	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2021	PACE Pharmacist										
QI21.18	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 10 business days in 2021 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2021	PACE Clinical Operations Manager										
QI21.19	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥65% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2021	Community-Based Program Manager										

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.20	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<2,857 hospital days per 1000 per year (5% decrease from 2020)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Clinical Director										
QI21.21	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<807 emergency room visits per 1000 per year (maintain improvements made in 2020)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Clinical Director										
QI21.22	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<15% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2021	PACE Clinical Director										
QI21.23	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Center Manager										
QI21.24	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager										
QI21.25	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60%) in 2021	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager										
QI21.26	Improve Participant Experience	Transportation	l00% of transportation trips will be less than 60 minutes in 2021	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2021	PACE Center Manager										
QI21.27	Improve Participant Experience	Transportation	≥92% of all transportation rides will be on-time in 2021	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2021	PACE Center Manager										
QI21.28	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2021	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.29	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2021	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

Back to Agenda

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 25, 2021
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

7. Consider Recommending Board of Directors Approval of the 2020 CalOptima Utilization Management Program Evaluation and the 2021 CalOptima Utilization Management Program Description

Contacts

Tracy Hitzeman, RN, Executive Director, Clinical Operations, (714) 246-8549
Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887

Recommended Action

Recommend Board of Directors approval of the 2020 Utilization Management Program Evaluation and the 2021 Utilization Management Program Description

Background

CalOptima's Utilization Management (UM) Program describes how medically necessary and quality health care services are delivered to our Members in a coordinated, comprehensive, and culturally competent manner. The program ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does it encourage decisions that result in underutilization. Additionally, the UM Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") is reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes processes for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2021 UM Program Description to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory, contractual and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

Discussion

The 2021 Utilization Management Program is based on the Board-approved 2020 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) important aspects of care and service for all lines of business. It is consistent with regulatory and contractual requirements, NCQA standards and CalOptima's own Success Factors.

The revisions are summarized as follows:

Back to Agenda

1. Included initiatives to mitigate the impact of the COVID-19 public health emergency on the mental health of CalOptima Members and of health care inequities by race and ethnicity.

2. The transition of Medi-Cal outpatient pharmacy benefits to Medi-Cal Rx, currently planned to be effective April 1, 2021.

3. CalOptima's Health Homes program will support a sustained relationship with current providers of housing-related services and includes the one-year extension of the Orange County Whole Person Care pilot program.

4. Expansion of the Behavioral Health Integration responsibility to include outpatient and inpatient mental health care, and opioid and alcohol misuse screening and counseling, for CalOptima OneCare and OneCare Connect Members.

5. Added role of a Physical Therapist specializing in custom Durable Medical Equipment evaluation and quality monitoring nurses for UM activities and updated the description of responsibilities for various key positions.

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

Fiscal Impact

The recommended action to approve the 2020 UM Program Evaluation and the 2021 UM Program Description does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

Concurrence

CalOptima Utilization Management Subcommittee
CalOptima Quality Improvement Committee
Gary Crockett, Chief Counsel

Attachments

1. CalOptima Annual Review 2020 UM Program Evaluation _2021 Description
2. 2020 UM Program Evaluation
3. 2021 UM Program DRAFT FINAL redline
4. 2021 UM Program DRAFT FINAL clean

/s/ Richard Sanchez *02/17/2021*

Authorized Signature **Date**

Back to Agenda

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CalOptima

Better. Together.

Annual Review: 2020 UM Evaluation & 2021 UM Program

Board of Directors' Special Quality Assurance Committee Meeting

February 25, 2021

Tracy Hitzeman, RN, CCM

Executive Director Clinical Operations

Back to Agenda Back to Item

Utilization Management (UM) Program and Evaluation

- Annually, CalOptima evaluates the effectiveness of the UM Program:
  - Program structure
  - Responsibility for the UM program
  - New initiatives/programs, and
  - Program scope and processes used to determine benefit coverage and medical necessity
- Based upon the evaluation, the program is revised and updated for the following year
- The 2020 UM Evaluation and 2021 UM Program have been reviewed and approved by the Utilization Management Committee (UMC)

Back to Agenda

Back to Item

CalOptima
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2020 UM Program Evaluation

Program Section	Evaluation
Scope	○ New roles and responsibilities: ▪ Custom DME Specialist — Physical Therapist provides in-home assessments for members needing custom DME ▪ Inline Monitoring Nurses — Ensure compliance with internal monitoring activities and identification of opportunities for improvement.
Projects, Programs and Initiatives	○ Implemented auto authorization rules for select initial specialty consults ○ Developed enhanced tools and templates to standardized review processes/reinforced UM principles ○ Enhanced over and underutilization monitoring as a corporate-wide initiative ○ Increased oversight of Post-Stabilization Authorization process to ensure compliance with regulatory requirements

2021 UM Program Evaluation

Program Section	Evaluation
Projects, Programs and Initiatives	○ Implementation of the POD concept for processing prior authorizations ▪ Core group of individuals, Nurses and MAA's, who work as a team to process authorization requests ○ Extended authorization time frames in response to the COVID-19 pandemic ▪ No PA requirement for COVID testing, vaccinations, and related treatments and services ○ Successful transition of management of OC/OCC BH benefits from vendor to CalOptima ○ Retirement of BH Quality Improvement Subcommittee ○ Audit & Oversight Dept (A&O) oversight and monitoring of the health networks ▪ CAPs issued to the HNs in 2020 to improve compliance with regulatory standards.

2020 UM Program Evaluation

Program Section	Evaluation
Performance	○ Variation in UM performance metrics noted for Q2 & Q3 2020 for all LOBs — most likely due to COVID (↑ ALOS, Bed Days/K, Readmits; ↓ ED Use) ○ Referral volumes and online referrals ↑; Fax referrals ↓ ○ Pharmacy and LTSS consistently met TAT ○ IRR completed by all business units making UM decisions at 90% or higher

2021 UM Program Description

Program Section	Change	Rationale for Change
Signature Page	Updated Board QAC and Board of Directors Chairperson	Reflect current Board Committee Members
Program Initiatives: COVID-19	Impact and Mitigation of COVID-19, including adverse impact on mental health and health care inequities by race and ethnicity	Reflect impact of COVID-19 during 2020
WPC	Whole Person Care (WPC) pending approval for program 1 year extension	Include requested extension by DHCS
HHP	Health Homes Program (HHP) CalOptima members will continue their current providers for housing-related services	Added information on continuation of housing related services

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
Homeless Health Initiatives (HHI)	Clinical Field Team/Homeless Care Access Program protocols modified due to COVID-19. Recuperative Care a shared cost for CalOptima and the county.	Reflects updates to HHI
Pharmacy Program	Effective April 1, 2021, Medi-Cal Rx becomes responsible for outpatient pharmacy benefit for all CalOptima Medi-Cal members	Change to Medi-Cal outpatient pharmacy benefit administration
Virtual Care Strategy	Virtual Care Strategy implementation plan described goals are to improve member access and reduce wait times for in-person specialty visits	Addition of Virtual Care Strategy to Program

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
Population Health Management (PHM)	Updated strategy to mange CalOptima's diverse population by expanding the model of care approach, focusing on existing programs, and increasing provider awareness	Updated PHM Program strategy and approach
UM Program Goals	Identification of staff training needs- ensure UM workflow and process change expertise is developed and maintained as the standard	Continuous identification of improvement opportunities
Behavioral Health Integration	Description of mental health services available to OC/OCC members: outpatient and inpatient mental health care, and opioid treatment and alcohol misuse screening and counselling	Accurate description of available services

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
BH Directors: • Integration Clinical • Operations	Described these new roles in the UM Program for Behavioral Health (BH)	Critical for BH success with the OC/OCC transition
BH UM Resource	Update Medical Case Manager role (BH RN)	Update scope of role
UM Resources	Addition of two nurses to monitor departmental processes, ensure compliance to standards, and make recommendations for corrective actions	To maintain compliance with UM processes and improve performance
LTSS Resources	Program Manager to assist with program administration	Resource addition to LTSS program

Back to Agenda

Back to Item

CalOptima
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2021 UM Program (cont.)

Program Section	Change	Rationale for Change
UM Committee (UMC) Role	Review and recommend actions related to over/underutilization added to UMC role	Include over and underutilization monitoring in scope of UMC
Pharmacy and Therapeutics (P&T) Subcommittee Pharmacy determinations	Updated to reflect Medi-Cal Rx carve-out	Medi-Cal RX carve-out impact to P&T function
Authorization Types	CCS Numbered Letters (NLs) added as a guideline for Whole Child Model (WCM) members	Clarification of criteria used for WCM authorization types

2021 UM Program (cont.)

Program Section	Change	Rationale for Change
Hierarchy of Clinical Decision Making	Updated sequence of criteria used for medical necessity determinations	Clarify protocol for evidence-based guidelines use in the UM process
Over/under utilization	Added Clinical Process Excellence and UMC as participants in monitoring metrics, performance, trends and suggesting actions necessary	Expand agency-wide monitoring of potential over and under utilization
Communications	Detailed process for communications received after normal business hours and response time	Manage expectations of managing communication requests after hours

Our Mission

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

Back to Agenda

Back to Item

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2020 CalOptima Utilization Management Program Evaluation

I. EXECUTIVE SUMMARY

The 2020 Utilization Management (UM) Program describes CalOptima's activities to provide optimum utilization for members with access to quality health care services delivered in a cost-effective and compassionate manner.

Annually, CalOptima evaluates the UM program structure, scope, processes, an information sources used to determine benefit coverage and medical necessity. This evaluation of UM activity is approved annually by the UM Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

During 2020, we broadened the scope of the UM program to ensure we are adequately meeting our members need, while maintaining compliance with recognized regulatory and accreditation standards. Specifically, we added the following roles:

- Addition of a Custom Durable Medical Equipment (DME) Physical Therapist (PT) to complete in home assessments of members needing custom DME.
- Addition of two (2) inline monitoring nurses to ensure compliance with internal UM activities and identification of opportunities for improvement to achieve and maintain compliance with regulatory and accreditation standards.

The structure and process of the UM department has not changed in relation to UM staff assigned activities. This includes those who have the authority to deny coverage, designated physician and behavioral health care practitioner involvement in the program, evaluation and development and approval of the UM program, process for handling appeals and making appeal determinations, as well as rule out within the organization related to the QI program and QI activities. Additionally, information sources used to determine benefit coverage remained current and appropriate. These are reviewed and approved annually at the UMC.

II. PROJECTS, PROGRAMS AND INITIATIVES

A. Utilization Management

In 2020, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. These projects included:

- Upgrades/enhancements to the Guiding (GC) Care Utilization Review Module in CalOptima's medical management system.
- Identifying through data analysis those services that can be automatically authorized in the UM system without clinician review, to improve the throughput time to provide authorizations to members to timely access needed care.

- Development of tools, such as documentation templates for physical therapy, occupational therapy and speech therapy Physical Therapy (PT), Occupational Therapy (OT) Speech Therapy (ST), as well as training focused on improving documentation requirements and UM processes in an effort to improve and maintain compliance with UM requirements.
- Continued development of CalOptima Reporting Environment (CORE) to align operational reports with the data structure in GC and to continue to identify opportunities for process improvement.
- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes.
- Extended authorization time frames, relaxing UM requirements for those members impacted by the public health emergency COVID-19 pandemic, as well as tracking and reporting of positive members, hospitalizations, and deaths.
- Fully developed an organization wide over and underutilization monitoring process to ensure members receive the appropriate care, timely and frequency to keep them well.
- Increased oversight of post-stabilization process to ensure that members requiring post stabilization care are afforded that care and compliant with regulatory requirements.
- Tested to determine if changing our staffing model to a POD approach, or a group of 3 nurses and 3 MAAs, would improve efficiency, consistency, and timeliness of authorization requests, which if successful would be spread to the entire prior authorization department in 2021.

The Medical Director of UM supported the UM process by providing clinical oversight for the administration of the UM Program and was very engaged during this year. He/she also supported the UM process by ensuring that treatment requests were processed in accordance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluated the program's effectiveness against established goals.

For UM Program areas that did not meet the approved goals, modifications to program activities were proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan was presented and approved by the UMC. Those changes were implemented by the UM Leadership and department staff.

The UM Medical Director supported provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This committee evaluates new and modified benefits to determine the need for prior authorization and it led by the UM Medical Director. Those services not requiring PA led to provider and member satisfaction by allowing the provider to administer these services in a timely manner due to not requiring a PA. The UM Medical Director also chaired the bi-weekly UMWG and provided input to the development and processes of UM Program to ensure quality, cost-effective services and care are delivered to CalOptima members. The UM Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, and discussed appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisted with discharge planning management. The director also provided education to the team to ensure understanding of the clinical basis for decisions.

The UM Medical Director also provided focused education on specific topics including genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

The Behavioral Health (BH) Medical Director was also very involved in the UM program development and administration. This was evidenced by providing input on the program to ensure all BH activities were integrated and aligned with the medical program and ensured compliance with UM regulatory and accreditation requirements. The BH Medical Director also participated in the UMWG, UMC and BMSC meetings to ensure adequate representation of BH and ensure that members BH needs are identified, considered and handled appropriately. The BH Medical Director also represented CalOptima at various meetings and collaborations related to the BH needs of the population and transgender services, including Orange county work groups focused on this population and working with Orange County Legal Aid to ensure services are provided to this population. The Director was very involved in the formation and implementation of policies and procedures, to ensure that appropriate changes are made based on state and federal guidance that was received throughout the year such as All-Plan Letters and other sources of regulatory updates.

In 2020, both the UM Medical Director and BH Medical Director supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2020, CalOptima continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination and Quality Improvement (QI). The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines.

For OneCare (OC) and OneCare Connect (OCC), CalOptima successfully transitioned in 2020 the management of behavioral health (BH) benefits from Magellan Health to CalOptima internal operations similar to the structure we have established for Medi-Cal. The BHI department is now directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

The Behavioral Health Quality Improvement (BHQI) subcommittee was retired in 2020. Objectives of this subcommittee were incorporated into CalOptima's committee structure including QIC, UMC, Member Experience Committee (MEMX), and Grievances, Appeals, and Resolutions (GARS) subcommittee. The goal is to further enhance the integration of behavioral health into CalOptima's programs and functions. The BH Medical Director and Directors of Behavioral Health Services participated in QIC and other subcommittees. In addition, Orange County Mental Health Plan Medical Director was added to the QIC membership to promote behavioral health integration for individuals with severe and persistent mental illness. In 2020 the BHQI workgroup continued to meet on a monthly basis to develop and implement BH quality initiatives. This internal group served to address suggestions from QIC and other subcommittees to identify areas of improvement, strengthen interventions, review performance data and improve the member experience.

C. UM Data Management

The UM data report's design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff. Together with UM department subject matter experts, EA and IS maintained a focused effort to improve the understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks

(HNs). Further refinement of data (XML) file format for HN submission of data elements included authorization information that led to increased reliability of reports and improved the usefulness of information. Additional efforts are planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by configuring standard queries of the data mart.

D. UM Delegated Provider Oversight

The external A&O department within CalOptima, provides HN oversight to ensure HN compliance with regulatory requirements. Their oversight is comprised of monthly auditing of UM files, as well as other delegated functions, to ensure compliance. Additionally, it performs an in-depth annual audit of each HN to ensure compliance with CalOptima and regulatory requirements. HN performance is monitored via a monthly delegation oversight dashboard, which is segmented by line of business. This dashboard includes performance for all aspects of A&O monitoring, including UM, as well as the identification of trends. A&O provided corrective action plans (CAPs) to those HN who were not meeting delegation requirements. It is also worth noting that due to the COVID-19 pandemic, it was necessary to suspend some of the monthly audits, which impacts overall performance of the HNs.

Areas of focus for the monthly audits are:

- **Timeliness**: Meeting turnaround time (TAT) for routine and urgent authorization requests related to timeliness of decision and notification. The goal for this metric is 98% or greater.
- **Clinical decision making**: Appropriateness of clinical decision making for authorization requests approved, denied or modified.
- **Notifications**: Compliance with regulatory standards related to member notification of denials by reviewing the Notice of Action sent to the member indicating that the service was denied or modified.

Medi-Cal

HN oversight performance below, reveals that there are opportunities to improve TAT for urgent authorization requests, clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

Medi-Cal 2020 HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=11)	Issues Identified
Routine TAT Timeliness	98.8–100%	11	N/A
Urgent TAT Timeliness	96.45–99.82%	3	Did not meet TAT for urgent authorization requests, as well as member and provider notification timely
Clinical Decision Making	67–100%	3	Failure to cite criteria used in making the medical necessity determination, failure to obtain clinical info to support the request and failure to use the appropriate professional for making the clinical decision

Notifications	75–100%	3	Failure to use lay language to describe why a service did not meet criteria, notifications to member not in threshold language, failure to provide peer-to-peer with medical reviewer and failure to indicate the name and contact information for healthcare professional responsible for the decision to deny

The A&O department issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as, but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations.

OCC

HN oversight performance below reveals that there are opportunities to improve clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

OneCare Connect 2020 HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=10)	Issues Identified
Routine TAT Timeliness	99–100%	10	N/A
Urgent TAT Timeliness	98.57–100%	10	N/A
Clinical Decision Making	33–100%	4	Failure to cite criteria for decision making
Notifications	78–100%	5	Failure to cite criteria for decision, failure to provide notification in members preferred language and lack of lay language description in notification to member.

A&O issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations within regulatory requirements.

OC

HN oversight performance below reveals that there are opportunities to improve TAT, clinical decision making, and notification sent to the members about the decision for the authorization request. It is worth noting that OC has 1,601 members across 8 HNs, which means 1 non-compliant file will decrease compliance below the threshold of 98%.

OneCare 2020 HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=8)	Issues Identified
Routine TAT Timeliness	67.14–99.78%	4	Failure to provide timely provider notification
Urgent TAT Timeliness	10.37–97.5%	0	Failure to provide timely provider notification
Clinical Decision Making	84–100%	5	Use of lay language to identify why request did not meet criteria, failure to cite criteria for decision and failure to use CMS notification template.
Notifications	67–100%	5	Failure to describe why request did not meet lay language

CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal Shared Risk

- **Average Length of Stay (ALOS):** For Seniors and Persons with Disabilities (SPD) and Temporary Assistance for Needy Families (TANF) >18 aid code categories, ALOS trended downward for the final quarter in 2019 and the first quarter of 2020, and subsequently trended upward through the third quarter of 2020. The ALOS trend for members in TANF ≤ 18 aid code category shows a downward trend for the final quarter of 2019 through the second quarter in 2020 with a slight uptick in the third quarter 2020.
- **Bed Days/Per Thousand Members Per Year (PTMPY):** SPD and TANF >18 subpopulations consistently met the 2020 goal, with only a slight increase in Q3 2020 for the SPD group. The TANF ≤18 exceeded the goal for every quarter except Q2 2020.
- **Readmissions:** Readmissions were stable for the SPD and TANF >18 subpopulations at approximately 23% and 17% respectively. TANF ≤18 ended 2019 at 12% and decreased to 8% for the first three quarters of 2020.
- **ED Visits/PTMPY:**
    - **SPD:** Goal was met for all four quarters of the reporting data.
    - **TANF ≤ 18:** Goal was met for all quarters except Q1 2020 with a .69% increase above

goal threshold.

- **TANF > 18:** Goal was not met in Q4 2019 and Q1 2020 but fell within desired threshold for Q2 and Q3 2020.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

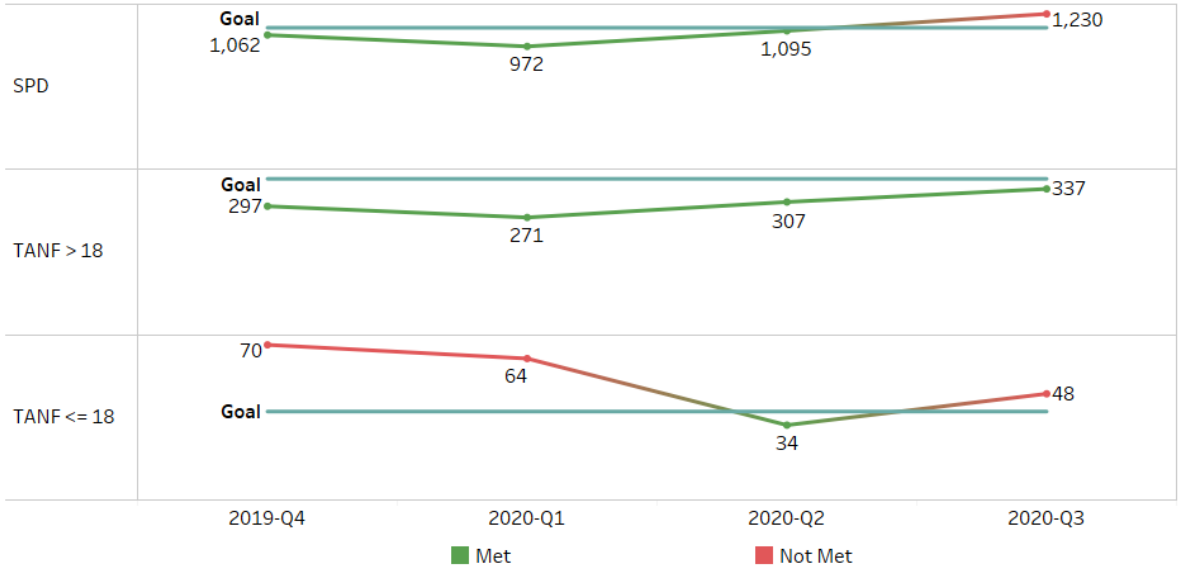
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.5	5.0	7.1	7.2
	Bed Days PTMPY	1,062	972	1,095	1,230
	Pcnt Re-Admits	22%	22%	23%	23%
	ED Visits PTMPY	625	603	419	500
TANF > 18	ALOS	4.4	4.3	5.7	5.6
	Bed Days PTMPY	297	271	307	337
	Pcnt Re-Admits	18%	17%	17%	17%
	ED Visits PTMPY	416	434	304	342
TANF <= 18	ALOS	4.0	3.5	3.3	4.6
	Bed Days PTMPY	70	64	34	48
	Pcnt Re-Admits	12%	8%	8%	8%
	ED Visits PTMPY	349	377	109	146

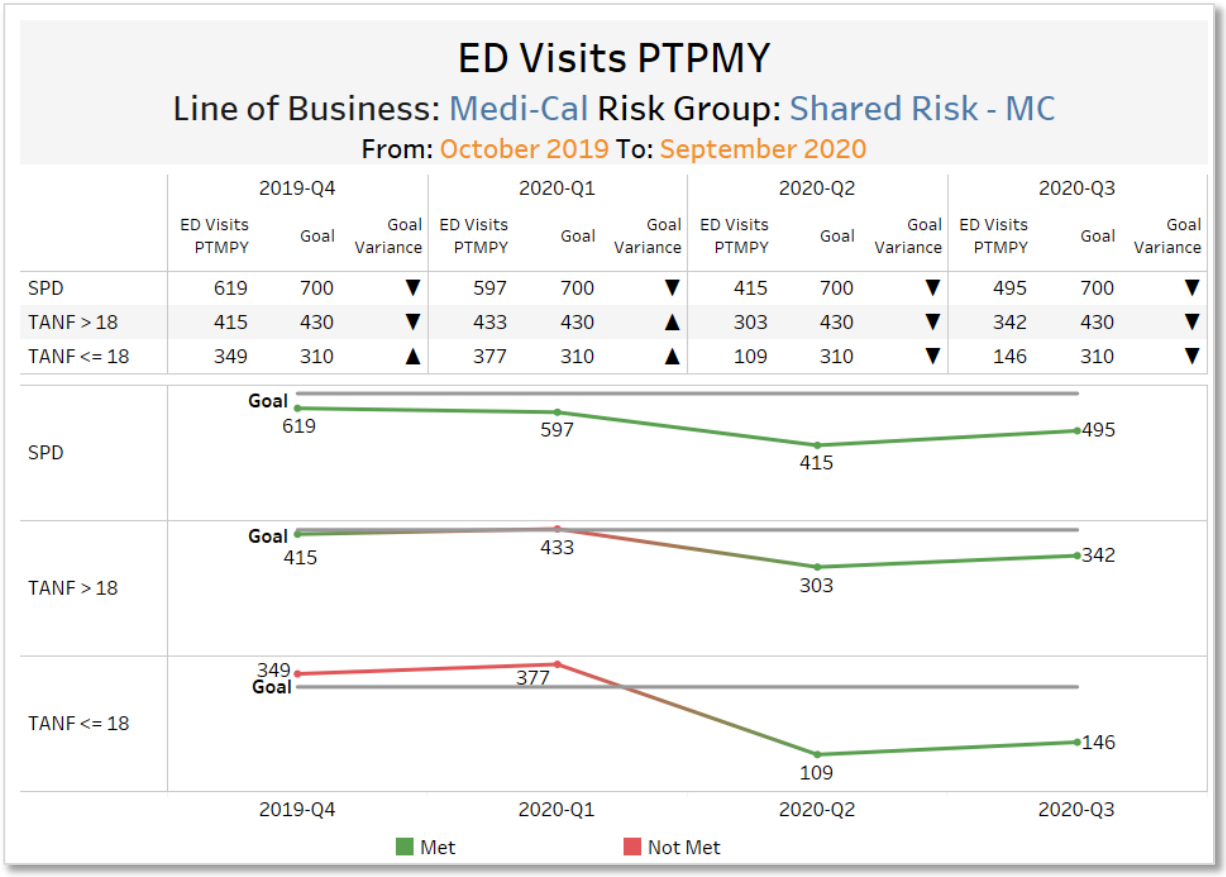
Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,062	1,120	▼	972	1,120	▼	1,095	1,120	▼	1,230	1,120	▲
TANF > 18	297	360	▼	271	360	▼	307	360	▼	337	360	▼
TANF <= 18	70	40	▲	64	40	▲	34	40	▼	48	40	▲





Medi-Cal CCN

- **Average Length of Stay**
  - **SPD and TANF > 18:** Stable for Q4 2019 and Q1 2020, increases for Q2 and Q3 2020.
  - **TANF ≤ 18:** Trended upward for the first three quarters of the reporting period and dips slightly in Q3 2020.
- **Bed Days/PTMPY:** SPD bed days were consistently above the goal threshold for all four quarters by an average of approximately 7.4%. TANF subpopulations consistently met the goal for all four quarters.
- **Readmissions:** SPD readmissions increased for the first three quarters of the reporting period and decreased by 5 percentage points in Q3 2020. TANF >18 readmissions were mildly volatile during this period, decreasing in Q4 2019 and Q2 2020, increasing in Q1 and Q3 2020. TANF ≤ 18 increased from Q4 2019 through Q2 2020 and dropped by 15 percentage points in Q3 2020.
- **ED Visits/PTMPY**
  - **SPD:** Goal was not met in Q4 2019 and Q1 2020, met goal for remaining quarters.
  - **TANF > 18:** Goal was not met in Q4 2019 and Q1 2020, met goal for remaining quarters.
  - **TANF ≤ 18:** Goal was met for all four quarters.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

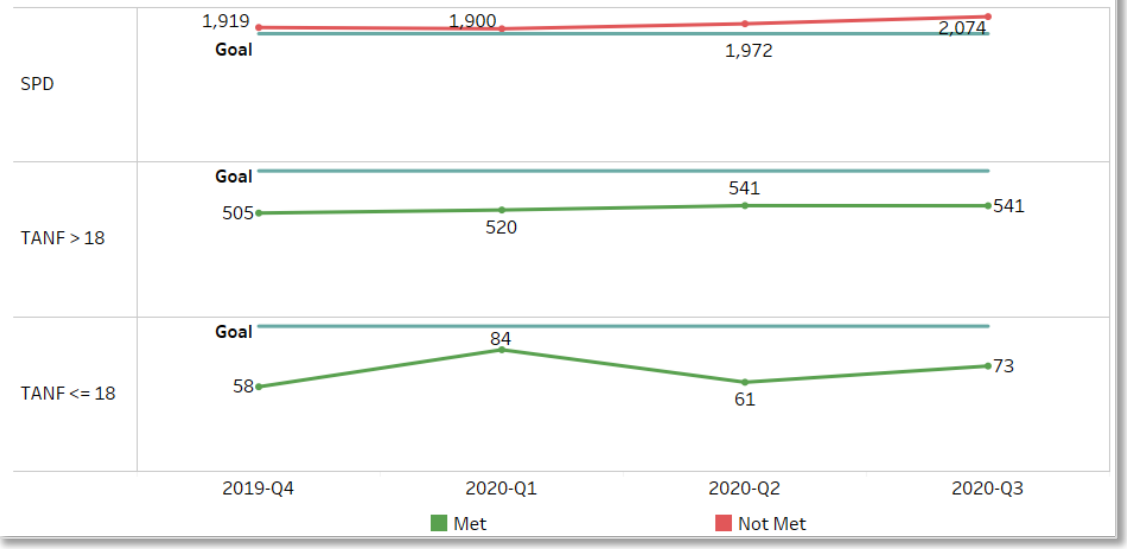
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.6	5.8	7.7	7.2
	Bed Days PTMPY	1,919	1,900	1,972	2,074
	Pcnt Re-Admits	31%	34%	35%	30%
	ED Visits PTMPY	827	874	484	582
TANF > 18	ALOS	5.5	5.5	6.6	6.5
	Bed Days PTMPY	505	520	541	541
	Pcnt Re-Admits	26%	28%	25%	30%
	ED Visits PTMPY	589	582	382	448
TANF <= 18	ALOS	3.3	4.4	5.6	5.5
	Bed Days PTMPY	58	84	61	73
	Pcnt Re-Admits	9%	13%	21%	6%
	ED Visits PTMPY	444	453	131	183

Bed Days PTPMY

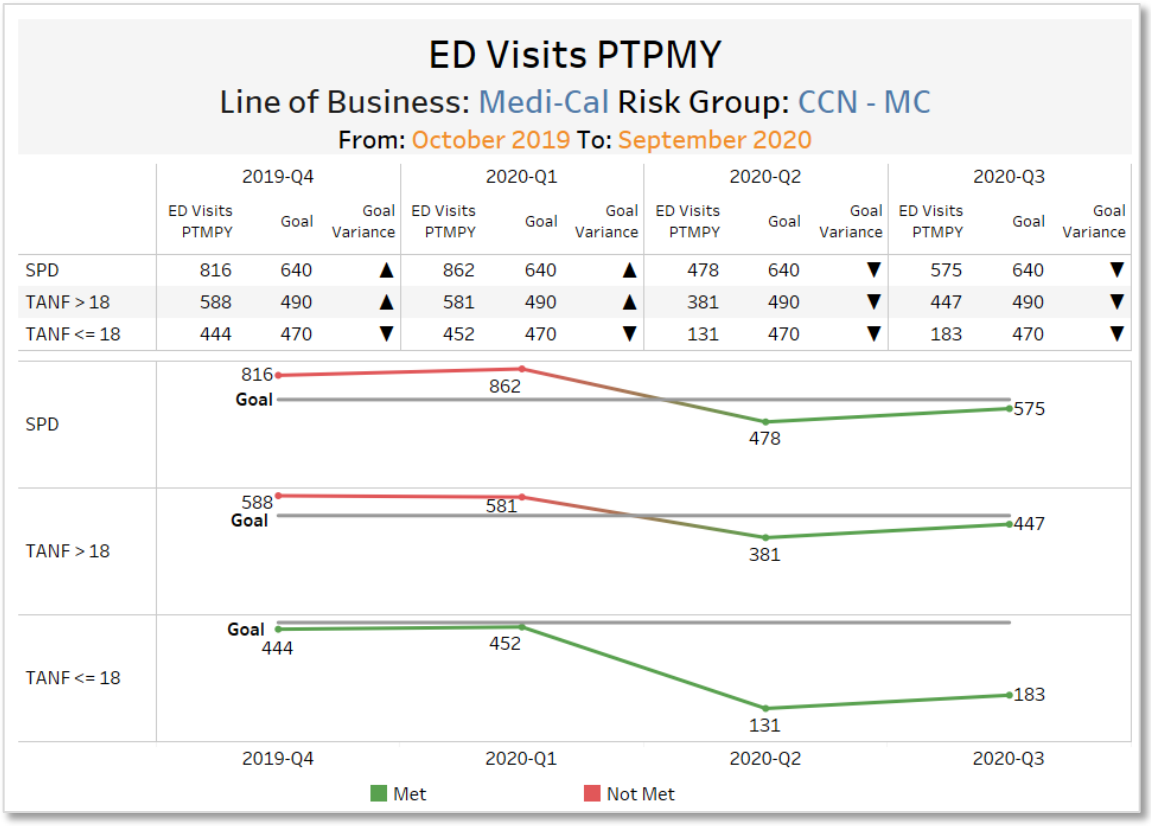
Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,919	1,830	▲	1,900	1,830	▲	1,972	1,830	▲	2,074	1,830	▲
TANF > 18	505	710	▼	520	710	▼	541	710	▼	541	710	▼
TANF <= 18	58	100	▼	84	100	▼	61	100	▼	73	100	▼



Back to Agenda Back to Item



CalOptima Direct Administrative (CODA)

- **Average Length of Stay:**
  - **SPD:** Consistently increases through Q4 2019 and Q2 2020, dips slightly in Q3.
  - **TANF >18/ TANF≤18:** Increases consistently over the four quarters reported.
- **Bed Days/PTMPY:** Both SPD and TANF >18 was consistently within the goal; however, SPD did not meet the goal for Q3 2020. TANF ≤18 did not meet the goal for all four quarters reported.
- **Readmissions:** SPD and TANF ≤18 increase slightly between Q4 2019 and Q1 2020 and subsequently decrease sharply through Q3 2020. TANF >18 remained a little more stable, hovering between 10 and 18%.
- **ED Visits/PTMPY:** No SPD data for ED visits, both TANF subpopulations met the goal for all four quarters.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

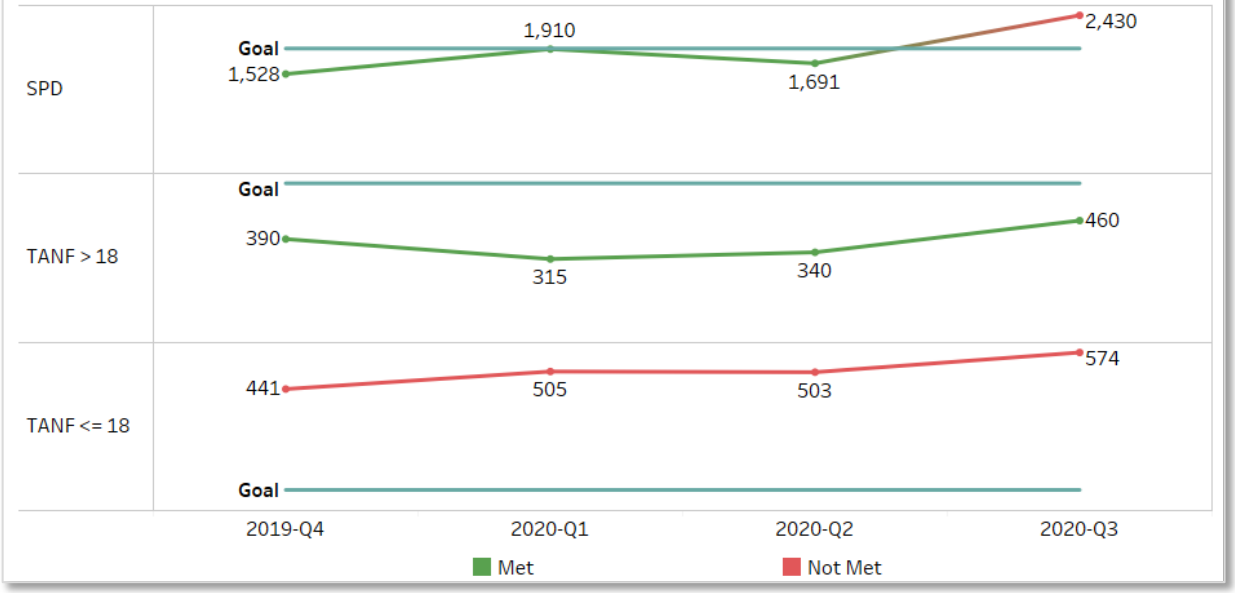
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	6.2	7.4	10.7	9.5
	Bed Days PTMPY	1,528	1,910	1,691	2,430
	Pcnt Re-Admits	23%	26%	14%	4%
	ED Visits PTMPY				
TANF > 18	ALOS	5.0	5.8	6.1	7.6
	Bed Days PTMPY	390	315	340	460
	Pcnt Re-Admits	17%	13%	18%	10%
	ED Visits PTMPY	7	1		1
TANF <= 18	ALOS	8.8	9.5	12.5	12.4
	Bed Days PTMPY	441	505	503	574
	Pcnt Re-Admits	6%	8%	3%	0%
	ED Visits PTMPY	13		1	

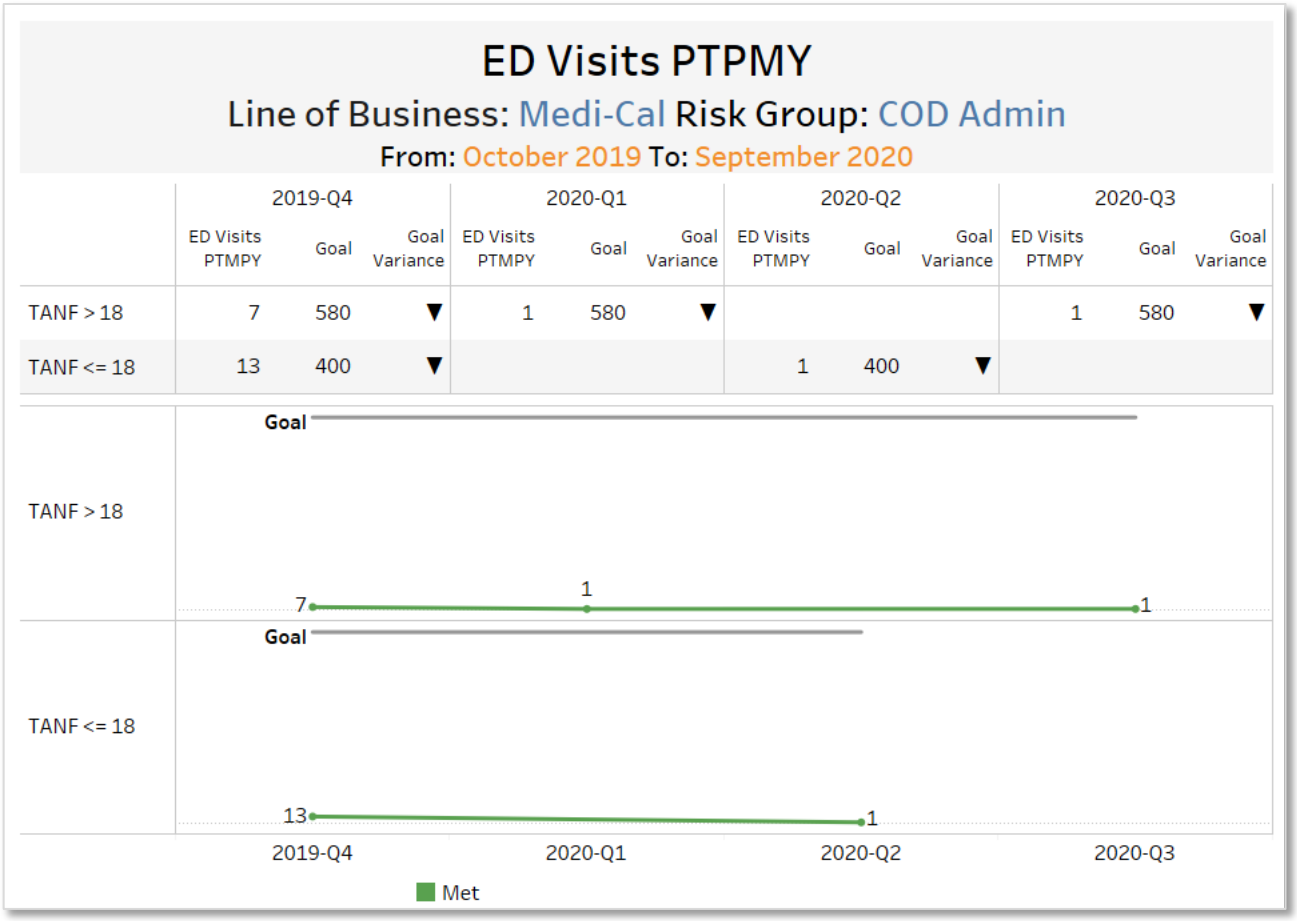
Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,528	1,920	▼	1,910	1,920	▼	1,691	1,920	▼	2,430	1,920	▲
TANF > 18	390	600	▼	315	600	▼	340	600	▼	460	600	▼
TANF <= 18	441	75	▲	505	75	▲	503	75	▲	574	75	▲





OneCare Connect Shared Risk

- **Average Length of Stay:**
  - **SPD:** Consistent from Q4 2019 through Q1 2020, rose slightly in Q2 and Q3 2020.
  - **TANF >18:** Fluctuated between Q4 2019 and Q2 2020 by about 1.1 average days.
- **Bed Days/PTMPY:** SPD group did not meet the goal in Q4 2019 and Q3 2020 but met the goal for the remaining quarters. There is not established goal for the TANF >18 group, however we do see a sharp increase in volume of 457% between Q4 2019 and Q1 2020 and then a 48% decrease in Q3 2020.
- **Readmissions:** SPD readmissions decrease by about 1% quarter-over-quarter. The TANF group increases by 9% in Q1 2020 and then sharply by 42% in Q2 2020.
- **ED Visits/PTMPY:** SPD ED visits consistently met the goal for all four quarters. The TANF >18 group does not have an established goal but remained consistent for all four quarters.

NOTE: For Q3 2020 there are not any data for TANF >18 at this time, most likely due to immaturity of the data.

Utilization Outcomes

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

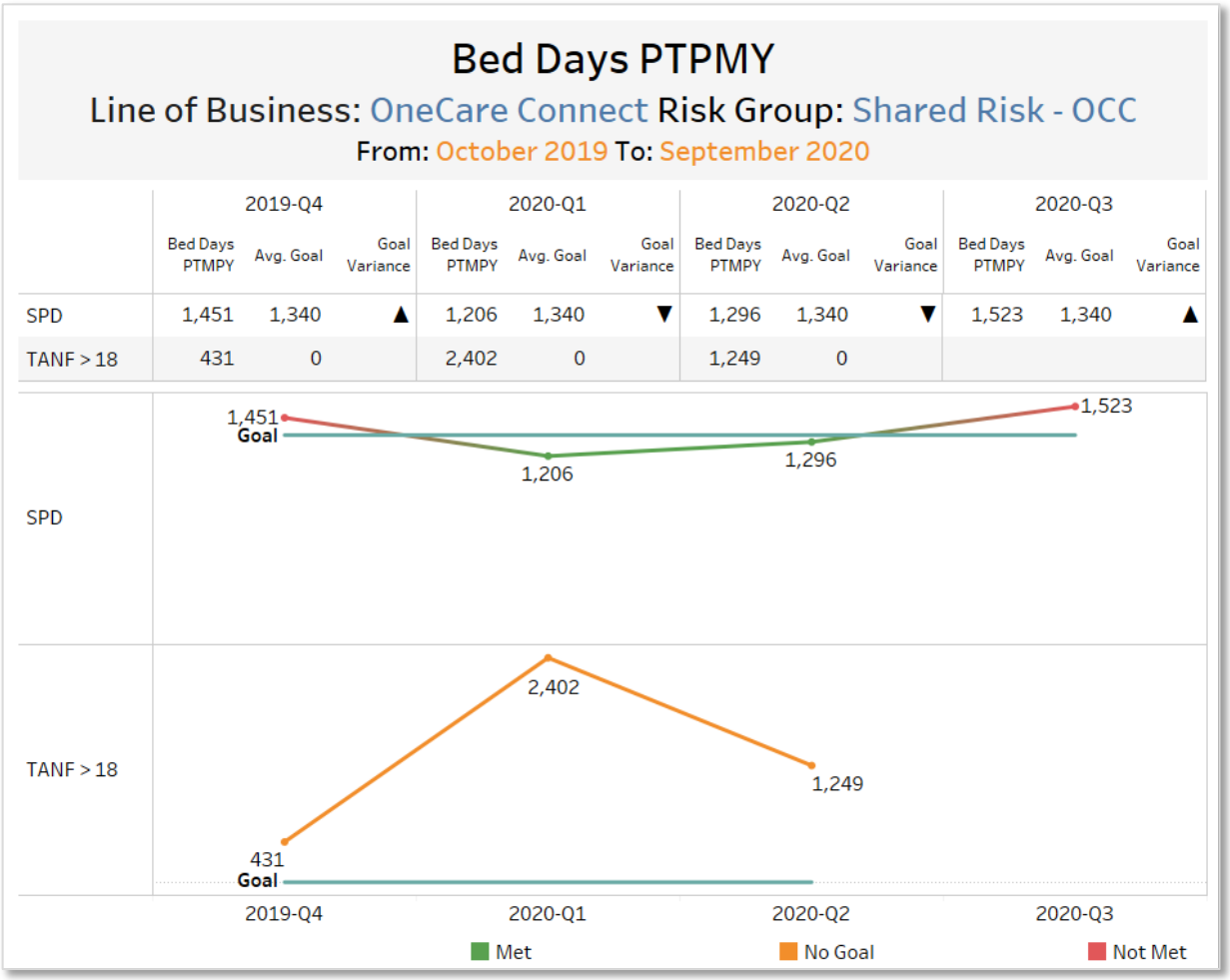
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.9	5.9	7.3	7.1
	Bed Days PTMPY	1,451	1,206	1,296	1,523
	Pcnt Re-Admits	24%	23%	22%	20%
	ED Visits PTMPY	370	363	240	262
TANF > 18	ALOS	4.5	6.0	5.3	
	Bed Days PTMPY	431	2,402	1,249	
	Pcnt Re-Admits	50%	50%	100%	
	ED Visits PTMPY	334	478	403	

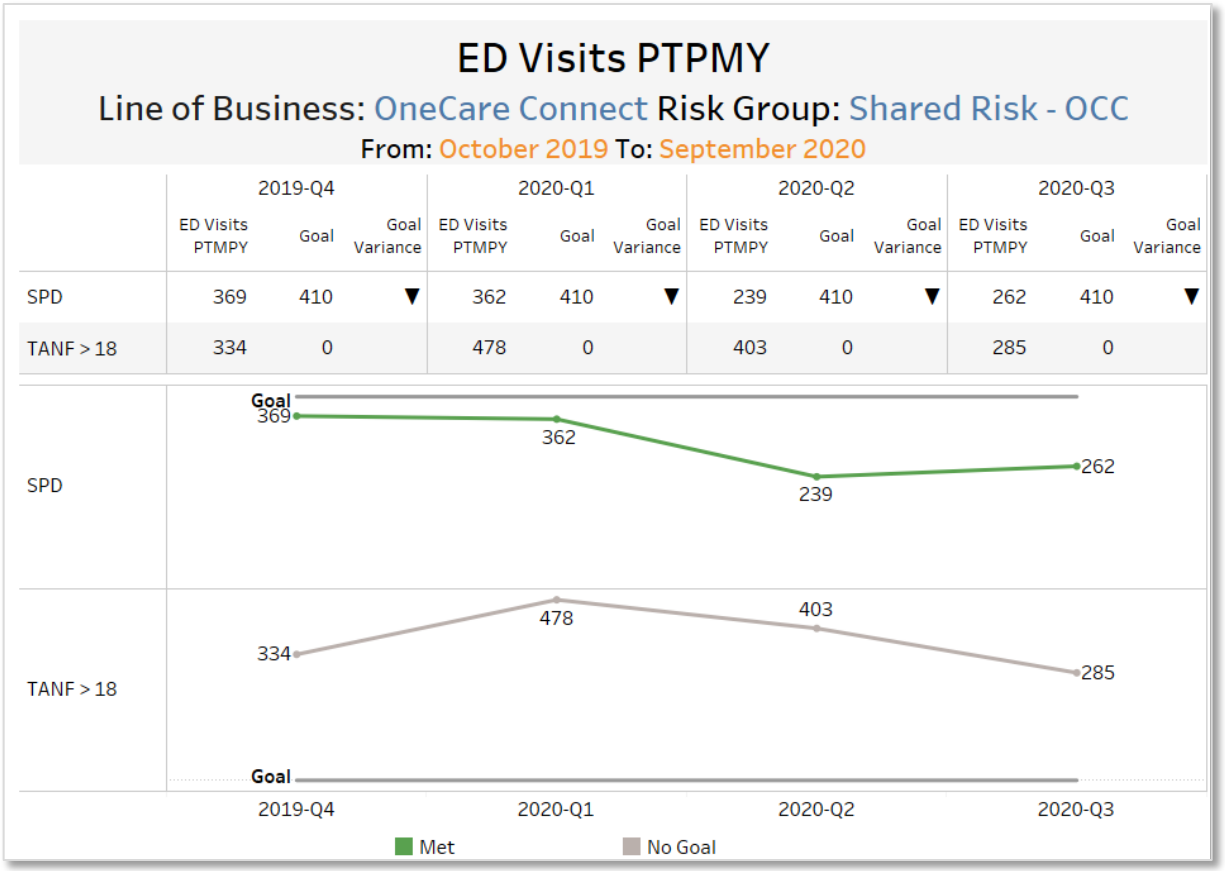
Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,451	1,340	▲	1,206	1,340	▼	1,296	1,340	▼	1,523	1,340	▲
TANF > 18	431	0		2,402	0		1,249	0				





OneCare Connect CCN

- **Average Length of Stay:** SPD population increased during each of the first 3 quarters of the reporting period, with a decrease in Q3 2020. The TANF >18 population was mildly volatile during the reporting period, spiking in Q1 2020.
- **Bed Days/PTPMY:** The SPD group met the goal for all four quarters. There is no established goal for the TANF >18 group, however, we do see volatility and a sharp increase of 309% in Q1 2020.
- **Readmissions:** SPD population remained stable during all four quarters, hovering between 27 and 33%. The TANF >18 group readmissions only occurred in Q1 2020 at 17%.
- **ED Visits/PTPMY:** SPD did not meet the goal for all four quarters. The TANF >18 population has no established goal but trended downward during the reporting period with a slight increase in Q3 2020.

Utilization Outcomes

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2019 To: September 2020

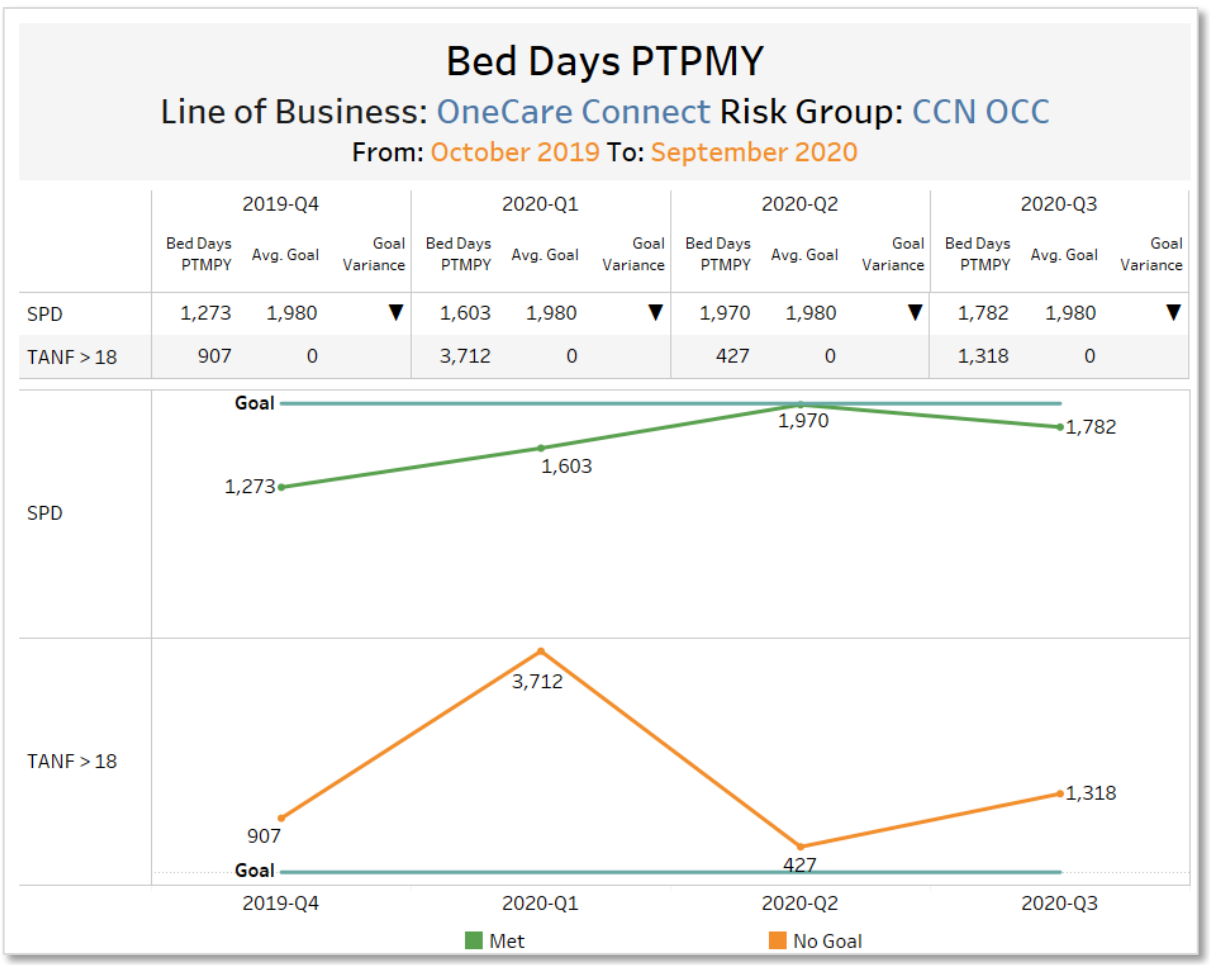
			2019-Q4	2020-Q1	2020-Q2	2020-Q3
CCN OCC	SPD	ALOS	4.8	6.0	8.2	7.2
		Bed Days PTMPY	1,273	1,603	1,970	1,782
		Pcnt Re-Admits	28%	28%	27%	33%
		ED Visits PTMPY	660	579	492	449
	TANF > 18	ALOS	2.7	8.0	1.7	3.5
		Bed Days PTMPY	907	3,712	427	1,318
		Pcnt Re-Admits	0%	17%	0%	0%
		ED Visits PTMPY	2,776	1,241	240	423

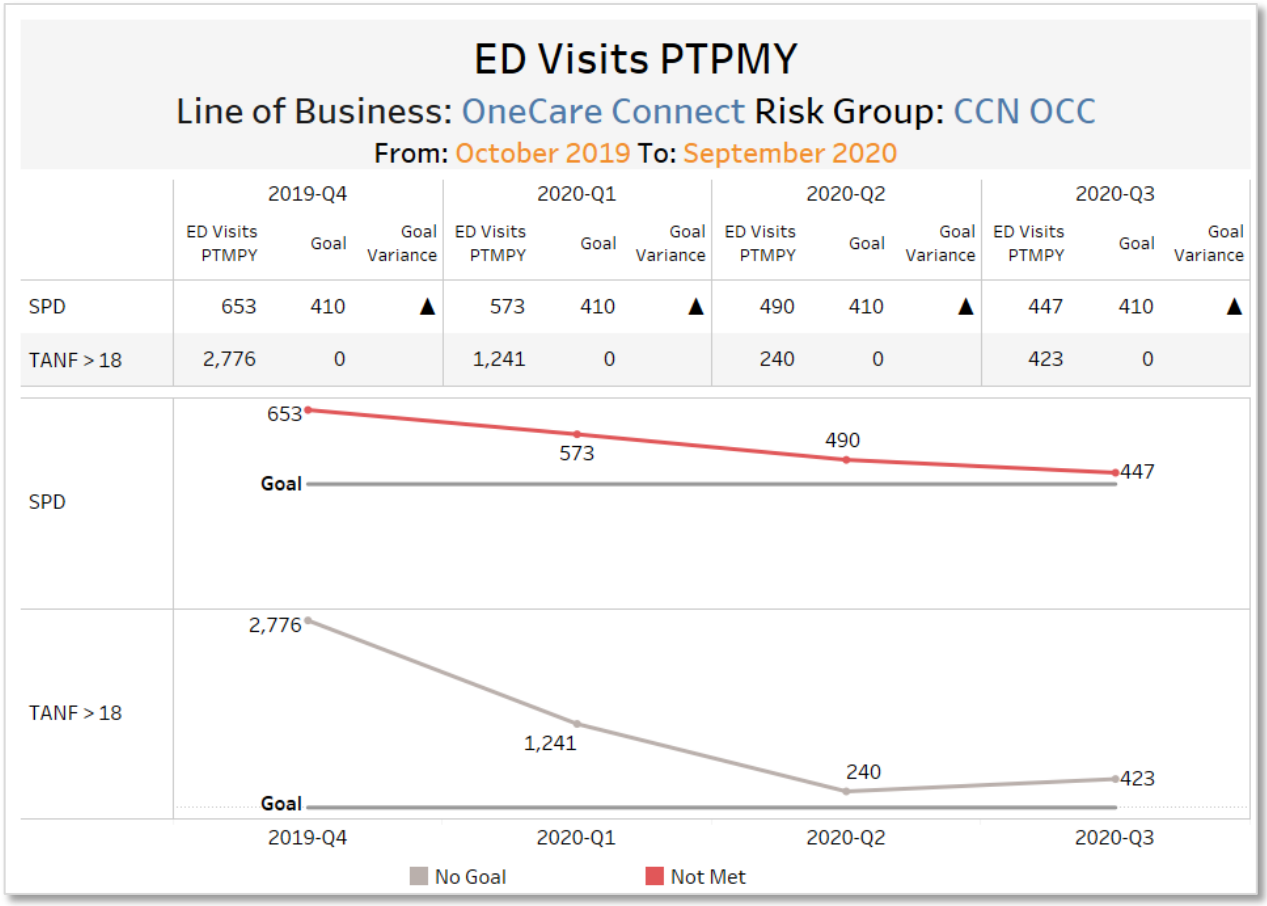
Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2019 To: September 2020

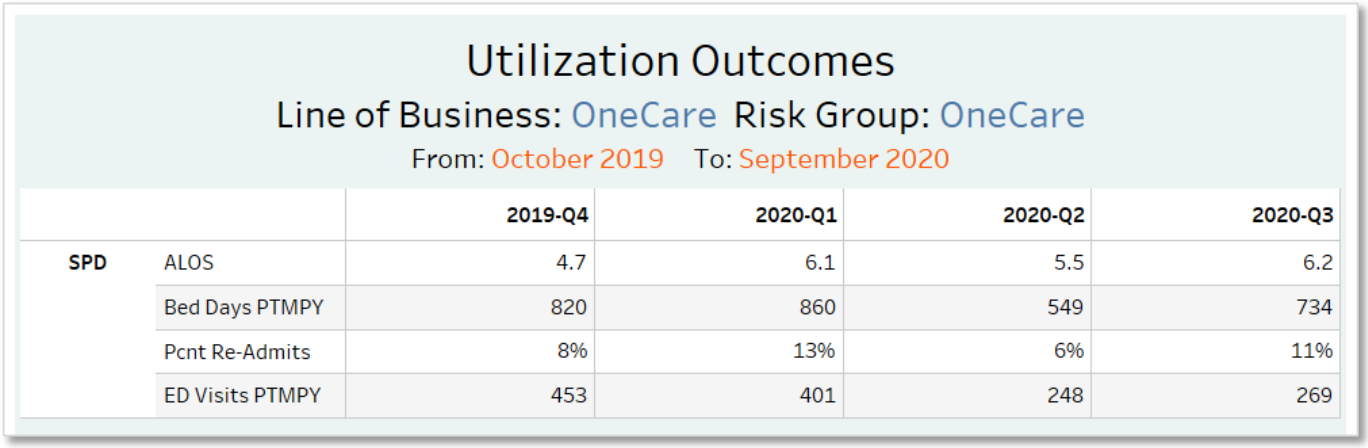
	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,273	1,980	▼	1,603	1,980	▼	1,970	1,980	▼	1,782	1,980	▼
TANF > 18	907	0		3,712	0		427	0		1,318	0	





OneCare

- **Average Length of Stay:** The SPD population slightly increases between Q4 2019 and Q1 2020 and between Q2 2020 and Q3 2020.
- **Bed Days/PTPMY:** The SPD population consistently met the goal for all four quarters.
- **Readmissions:** The SPD population increased slightly in Q1 2020 and Q3 2020.
- **ED Visits/PTPMY:** The SPD population consistently met the goal for all four quarters.



Utilization Outcomes

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

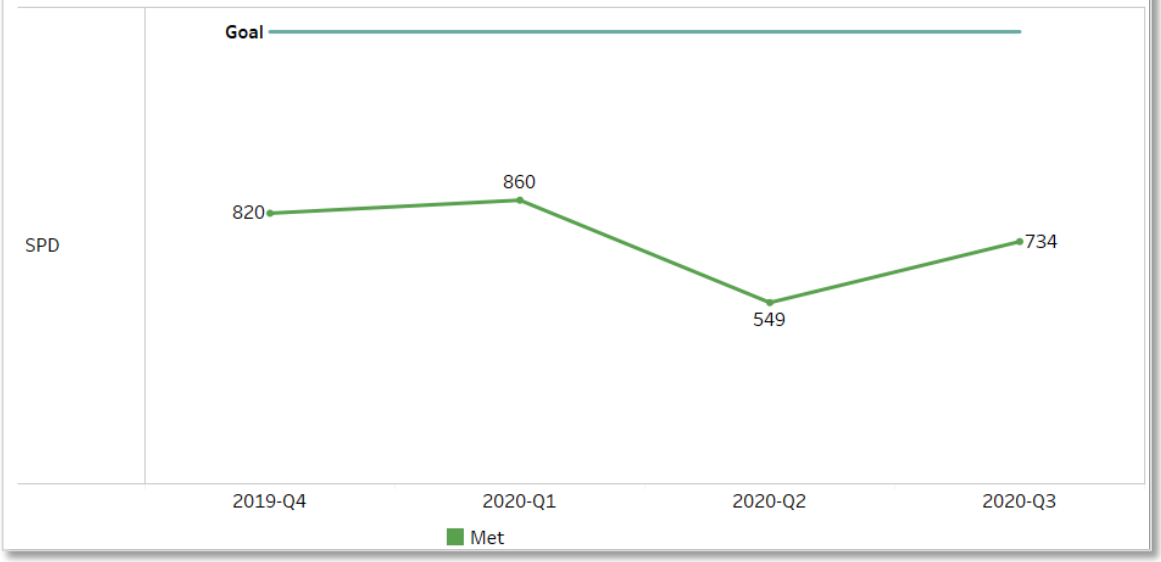
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	4.7	6.1	5.5	6.2
	Bed Days PTMPY	820	860	549	734
	Pcnt Re-Admits	8%	13%	6%	11%
	ED Visits PTMPY	453	401	248	269

Bed Days PTPMY

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	820	1,370	▼	860	1,370	▼	549	1,370	▼	734	1,370	▼

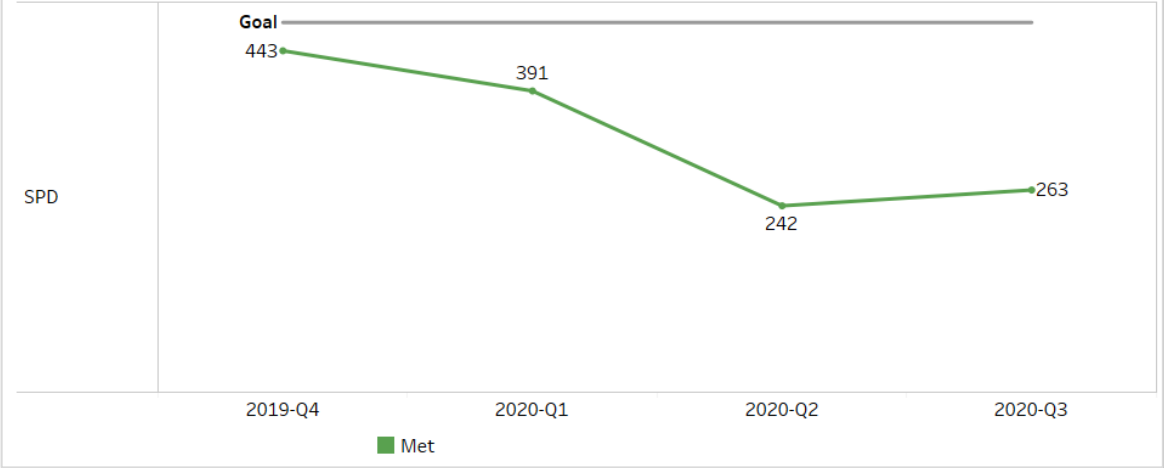


ED Visits PTPMY

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
SPD	443	480	▼	391	480	▼	242	480	▼	263	480	▼



Over and Underutilization

In 2020 the process for monitoring of over and underutilization was enhanced as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization and the development of a cross departmental dashboard, maintained by UM. Metrics were identified throughout the organization as good indicators of over and underutilization, as well as drill down into the metrics to ensure proper identification of over and underutilization. Metrics from the following area are included and will be reviewed on an annual basis to ensure they are indicative of over and underutilization monitoring. The metrics include inpatient and prior authorization UM measure, appeal volumes and overturn rate, member grievances, adult and children's access to PCP services, measures indicative of appropriate utilization for pharmaceuticals, outlier reporting from the fraud, waste and abuse department within CalOptima, referral pattern analyses, member utilization, UM related member complaints, potential quality issues (PQI) monitoring, and measures related to behavioral health care.

Over and underutilization was monitored, tracked, managed, and reported by UM during 2020 and reported to UMC, QIC and the Quality Assurance Committee (QAC). Through quarter 3 of 2020, we identified one area of overutilization related pre-natal ultrasounds being ordered by one physician multiple times, when the recommendation is one ultrasound within 180 days and any others within that period will require prior authorization. Provider education has occurred via a memo and by provider relation outreach.

III. Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests — Medical

2020 — Summary of referral volume (Q4 2019 to Q3 2020)

Referrals Processed		Referrals Received		Turnaround Time Compliance (TAT)	
Routine	**138,240**	Faxed	**80,324**	Routine TAT	**99.22%**
Urgent	**16,918**	COLAS	**100,177**	Urgent TAT	**99.15%**
Retro	**9,356**	Auto Auth	**25,279**	Retro TAT	**99.83%**
Total	**155,158***	**Total**	**180,501**		

- Total volume of referrals shows a year-over-year increase 8,607 (5.9%) based on data from Q1–3 2019 compared to Q4 2019 through Q3 2020.
- Volume of faxed referrals decreased from Q1–3 2019 by 9,800 or 10.9%
- Volume of portal (COLA) referrals decreased from 2019 report by 365 or .36%

It is also worth noting that we have indicated the volume of referrals that were automatically authorized when submitted via our portal, as in April we implemented an auto authorization process for initial consults for 9 specialties, chosen based on analysis of data and meeting an approval rate of 99% or greater.

* The difference between referrals received and processed may be attributed to duplicate

submissions and/or requests that do not require authorization.

Online Referral Rate Submission

Online referral submission increased over the 3 quarters by 11% in 2020. In 2019, Q1–Q3, there were 91,334 online referrals and during the same period of 2020, there were 100,177.

- Referral TAT was compliant for all referral types in the first 3 quarters of 2020.

B. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance through Q3 2020:

LOB	TAT Compliance
Medi-Cal	98.1 %
OC	100%
OCC	99.4%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets were achieved for 2020.

C. Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for Q4 2020–Q3 2020:
  - CBAS CEDT: 100%
  - CBAS Routine: 100%
  - CBAS Expedited: None received
    - Members participating in CBAS Q4 2019 & Q1–Q3 2020: Potentially program-eligible members.

Year	Qtr.	LOB	Members Participating in CBAS Q4 2019-Q3 2020 / Potentially Program-Eligible Members	% Participating	Change from Previous Qtr.
2019	Q4	Medi-Cal	2,590 / 116,463	2.22%	↑
		OCC	195 / 14,160	1.38%	↑
2020	Q1	Medi-Cal	2,565 / 114,555	2.24%	↑
		OCC	194 / 14,191	1.37%	↑
	Q2	Medi-Cal	2,245 / 105,321	2.13%	↓
		OCC	170 / 14,408	1.18%	↓

	Q3	Medi-Cal	2,384 / 120,253	1.98%	↓
		OCC	164 / 14,711	1.11%	↓

- 80% of authorized CBAS participation days will be utilized/delivered (Q4 2019) to Q3 2020.

Year	Qtr.	CBAS Participation Days Used / Days Authorized	% Used	Change from Previous Qtr.
2019	Q4	98,616 / 133,320	73.97%	↓
2020	Q1	89,668 / 129,236	69.38%	↓
	Q2	105,758 / 129,144	81.89%	↑
	Q3	107,255 / 122,417	87.61%	↑

  - o LTC Routine: 98.99%
  - o LTC Urgent: None received
  - o MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

Year	Qtr.	Admissions/ Discharges	Change from Previous Qtr.
2019	Q4	34 / 34	No Change
2020	Q1	31 / 28	Admissions ↑
	Q2	24 / 14	Admissions ↓
	Q3	19 / 20	Admissions ↓

- MSSP Goal met. Continue with this goal.

D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2020. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	90%
UM Clinical Staff: Concurrent Review	90%
Physicians	97%
Pharmacy	100%
LTSS: LTC	100%
LTSS: CBAS	100%
LTSS: MSSP	Did not test in 2020

E. Denial (Letter) Process

Performance has continued to improve throughout 2020. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the HNs. A workgroup begun in 2020 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA 2020 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

IV. Utilization Performance / Outcomes

A. Facility Utilization — Facility Acute and Emergency Care

Analysis of inpatient and ED data in 2020 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of 2020 ED Data will be conducted, and additional interventions may be applied as needed. LTC Nursing facility members transitioned to the Community:

Year	Qtr.	LOB	LTC Nursing Facility Members Transition to the Community	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	182 / 5,133	3.55%	↑
		OCC	6 / 205	2.93%	↑
2020	Q1	Medi-Cal	163 / 5,181	3.15%	↓
		OCC	6 / 201	2.99%	↑
	Q2	Medi-Cal	148 / 5,192	2.85%	↓
		OCC	7 / 185	3.78%	↑

	Q3	Medi-Cal	158 / 4,738	3.33%	↑
		OCC	4 / 161	2.48%	↓

CBAS: Track CBAS participants who transition to LTC.

Yr.	Qtr.	LOB	CBAS participants who transition to LTC	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	8 / 2,590	0.31%	↑
		OCC	1 / 195	0.51%	↓
2020	Q1	Medi-Cal	10 / 2,565	0.39%	↑
		OCC	1 / 194	0.52%	↑
	Q2	Medi-Cal	4 / 2,345	0.17%	↓
		OCC	0 / 170	0.00%	↓
	Q3	Medi-Cal	7 / 2,384	0.29%	↑
		OCC	0 / 164	0.00%	←

LTC: Members residing in LTC: Potentially nursing home eligible members.

Year	Qtr.	LOB	Members Residing in LTC/ Potentially Nursing Home Eligible Members	% Residing in LTC	Change from Previous Qtr.
2019	Q4	Medi-Cal	5,133 / 116,443	4.41%	↓
		OCC	205 / 14,168	1.45%	↓
2020	Q1	Medi-Cal	5,181 / 114,555	4.52%	↑
		OCC	201 / 14,191	1.42%	↓
	Q2	Medi-Cal	5,192 / 105,321	4.93%	↑
		OCC	105 / 14,408	0.73%	↓
	Q3	Medi-Cal	4,738 / 120,253	3.94%	↓
		OCC	161 / 14,711	1.09%	↑

B. Pharmacy Utilization

- Retail Pharmacy: $PMPM costs from 4Q19 to 3Q20 are below goal for OneCare and

Medi-Cal, and above goal for OneCare Connect. Medi-Cal pharmacy costs increased 7% after the start of the Whole Child Model (WCM) on July 1, 2019. OneCare Connect drug cost increases are primarily driven by increased utilization of diabetes medications as well as drug price increases for a large number of branded medications.

LOB	Goal $PMPM	Actual $PMPM (Q4 2019–Q3 2020)
Medi-Cal	$71.57	$71.11
OC	$370.76	$370.10
OCC	$420.44	$433.98

- Opioid analgesic utilization (average morphine milligram equivalent) has decreased 11.2% from 4Q19 to 3Q20.

C. Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters.
  - New member orientation is available for all CalOptima members to better understand their benefits.
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website.
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed.
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members.
  - A Provider Toolkit is available on the CalOptima website for provider reference.
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers.
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In 2020, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making.
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed.
  - Overall improvement in audit scores for clinical decision making in 2020.

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2020, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
  - Access to providers, specifically providers no longer contracted with CalOptima.
  - Provider not seeing new patients.
  - Provider was unable to see the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Limitation of members ability to see certain providers, as there are some providers who only see members already affiliated with their organization.

- Provider concerns:
    - Most complaints from providers were related to changes in our portal to safeguard PHI and inability for them to self-serve to obtain information about their referral.

CalOptima is continually looking at improving access to providers, including alternative types of visits, such as telehealth. All member issues were resolved by either redirecting the members care to another specialist that is able to meet the member's needs. We are looking at ways to improve provider data in our systems, including finding a new product to use for provider data management that interfaces with multiple systems. Provider relations has also worked very diligently to ensure the provider data is accurate, by confirming information accuracy with providers.

Access to authorization data has been mitigated by adding safeguards within the portal to verify the provider has a relationship with the member and displaying the members phone number only on authorization notices to limit PHI exposure and ensure the provider is able to reach out to the member to deliver necessary care.

V. SUMMARY

In 2020, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers through the implementation of auto authorizations for select specialties. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance, maintenance of current policies and procedures, report development.

The UMC and the UM Medical Director and Behavioral Health Medical Director continue to guide and support CalOptima UM programs, both medical and behavioral. The UMC met six times in 2020, with two of the meeting being virtual. Pharmacy and Therapeutics Committee (P&T) and the BMSC reported quarterly to the UMC in 2020. Quarterly UM operational performance and health care utilization data and over and underutilization analysis and trends are presented, reviewed, and discussed at the UMC and guide future efforts of the CalOptima UM Program.

20210 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Back to Agenda Back to Item

~~2019~~ 2021 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

~~Paul Yost~~Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

~~Paul Yost~~Andrew Do~~, M.D.~~ **Date**

Back to Agenda Back to Item

TABLE OF CONTENTS

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members ~~is~~ was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

Our Values——CalOptima CARES

Collaboration:

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability:

We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect:

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence:

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members'

health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship:
We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures**,** including providing opportunities for stakeholder input.
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal
In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services
Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (~~OC~~ HCA).
- Substance use disorder services are administered by ~~OC~~ HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs
To ensure that clinical services as described above are accessible and available to members with special health care needs—such as seniors, people with disabilities and people with chronic conditions—CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including ~~Orange County Health Care Agency (OC~~ HCA~~)~~ and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare ~~-~~(HMO SNP)

Our OneCare (OC~~HMO SNP~~) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OneCare (OC) to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled,

dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral, and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits, such as vision care, gym benefits, over-the-counter medication benefits, and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail ~~elders~~ seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)

COVID-19 PHE created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 PHE, the Health Equity strategy, as well as the COVID-19 PHE Vaccination and Communication strategy. Additionally, UM requirements for COVID PHE screening, vaccinates and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 PHE shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 PHE analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 PHE adversely impacted the mental health of many members, especially children. ~~Hence~~Therefore, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 PHE.

~~:-The-itsW P-the- of many members, especially children, several trauma-~~

~~informed interventions are included in the 2021 QI Work Plan to address the toxic stress and (ACEs) related to the COVID-19 pandemic.~~

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the ~~OC~~ HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. ~~The WPC~~The WPC information sharing platform was launched in November 2018. ~~For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.~~WPC is scheduled to terminate December 31, 2020~~,~~; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicare Services (CMS) extend the pilot for an additional year

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance.

As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned~~s~~ to CalOptima in 2019 and will continue ~~indefinately~~indefinitely**.** Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with ~~OC~~ HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima ~~planned to~~ implemented HHP in ~~the following~~ two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD)~~;~~ and July 1, 2020, for members with serious mental illness (SMI) or ~~S~~serious ~~E~~emotional ~~D~~disturbance (SED~~MI~~). During implementation, HHP

~~CalOptima's goal is to~~ targeted the highest-risk 3–5 ~~percent~~ % of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME)

will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC, who are also eligible for the HHP, to continue with their current WPC providers for their housing related services. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the Ccounty. Homeless health initiatives supported by CalOptima include:

- Recuperative Care——As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with Whole-Person Care program, and the CalOptima Board of Director's has authorizationed tothe extendsion of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.
- Medical Respite Care——As an extension to the recuperative care program, CalOptima provideds a grant to HCA to additionalprovide additional respite care beyond the 90 days of recuperative care under the Whole Person Care program. These grant funds have been exhausted.
- Clinical Field Teams——In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency'sHCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19, these services are available via telehealth, in addition to in person.

——Homeless Clinical Access Program——Thise Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through

mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. CalOptima provides preventive screenings, chronic care, care coordination and follow up.

-
- Hospital Discharge Process for Members Experiencing Homelessness——Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

It is expected that, e~~E~~ffective April 1, 2021, the Department of Health Care Service (DHCS) ~~is~~will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/ prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect the OneCare~~/~~ or OneCare Connect lines of business.

Virtual Care Strategy

In 2021, federal and state rules and regulations provided limited waivers for telehealth due to the ~~COVID-19~~COVID-19 PHE ~~pandemic~~, that enabled CalOptima to accelerate its virtual care strategy under ~~COVID-19~~COVID-19 PHE shelter-at-home measures. Members were able to receive appropriate health care services through telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.
2. Leverage existing delivery model where possible.
3. Be proactive in seeking out opportunities to innovate.
4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work ~~p~~Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

- ——CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.~~The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.~~

~~**Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under new state requirements.**~~

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping m~~M~~embers h~~H~~ealthy
2. Managing m~~M~~embers with c~~E~~merging r~~R~~isks
3. Patient s~~S~~afety or o~~O~~utcomes a~~A~~cross s~~S~~ettings
4. Managing m~~M~~ultiple c~~C~~hronic c~~C~~onditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

~~CalOptima has developed a comprehensive PHM Strategy, which includes actions to address the needs of our culturally diverse members across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards.. CalOptima's PHM Strategy aims to ensure that care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.~~

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical

services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs.– Quality Initiatives for 20210 are tracked in the QI Work ~~p~~Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing ~~the~~ evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation, and care delivery system to improve member - focused trauma informed care to be consistent with NCQA ~~2020~~ Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-~~-~~Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

~~**CalOptima's PHM Strategy is based on numerous efforts to assess the health and well-being of**~~

~~**our members, such as the Member Health Needs Assessment. It focused on ethnic and linguistic minorities within the Medi-Cal**~~

~~POPULATION FROM BIRTH TO AGE 101.~~

~~THE PHM STRATEGY ADDRESSES THE UNIQUE NEEDS AND CHALLENGES OF SPECIFIC ETHNIC COMMUNITIES INCLUDING ECONOMIC, SOCIAL, SPIRITUAL, AND ENVIRONMENTAL STRESSORS, TO IMPROVE HEALTH OUTCOMES.~~

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs ~~-~~providing health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-~~Administration~~ Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs, representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligible~~'~~s (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. ~~Members enrolled in CalOptima Direct-Administrative are not HN eligible.~~

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered ~~internally~~ directly by CalOptima and available for HN eligible members to select, supplementing the HN delivery model and creating additional capacity for ~~growth~~access.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

~~Health Network/Delegate~~	~~Medi-Cal~~	~~OneCare~~	~~OneCare Connect~~
~~AltaMed Health Services~~	~~SRG~~	~~SRG~~	~~SRG~~
~~AMVI/Prospect~~		~~SRG~~	
~~AMVI Care Health Network~~	~~PHC~~		~~PHC~~
~~Arta Western Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
~~CHOC Health Alliance~~	~~PHC~~		
~~Family Choice Health Network~~	~~PHC~~	~~SRG~~	~~SRG~~
~~Heritage~~	~~HMO~~		~~HMO~~
~~Kaiser Permanente~~	~~HMO~~		
~~Monarch Family HealthCare~~	~~HMO~~	~~SRG~~	~~HMO~~

~~Health Network/Delegate~~	~~Medi-Cal~~	~~OneCare~~	~~OneCare Connect~~
~~Noble Mid-Orange County~~	~~SRG~~	~~SRG~~	~~SRG~~
~~Prospect Medical Group~~	~~HMO~~		~~HMO~~
~~Talbert Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
~~United Care Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer s~~S~~ervices activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2020

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

Membership Data as of November 30, 2019

Total CalOptima Membership
755,539

Program	Members
Medi-Cal*	739,601
OneCare Connect	14,065
OneCare (HMO SNP)	1,498
Program of All-Inclusive Care for the Elderly (PACE)	375

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2021

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

Membership Data from November 30, 2020 Financial Information

Total CalOptima Membership
801,270

Program	Members
Medi-Cal*	784,665
OneCare Connect	14,587
OneCare (HMO SNP)	1,625
Program of All-Inclusive Care for the Elderly (PACE)	393

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior period adjustments

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
33%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for -review of health care services, treatment, and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, and home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA ~~S~~standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on Medical Necessity and/or benefit coverage.
- Identify and refer high-risk members to Case Management ~~P~~programs, including Complex Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate practitioners and other providers, including delegated HNs on CalOptima's UM Program, policies and procedures on an ongoing basis.
- Monitor utilization practice patterns of practitioners to identify variations from the standard

practice that may indicate need for additional education or support.

- Continuous identification of UM staff needs, and appropriate training delivered to address those needs, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality--based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.
The organization chart and the UM Program~~'s committees reporting structure~~ reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization ~~m~~Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee~~'~~s' charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the delegate's UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs' UM activities by the Audit and Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to

determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

LONG-TERM SUPPORT SERVICES ~~AND SUPPORTS~~

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- ~~Starting i~~In April 2020, all LTC ~~M~~member facility clinical reviews and medical necessity nursing facility visits were suspended due to the ~~COVID-19~~COVID-19 PHE health emergency. ~~-~~ All clinical review is now ~~being~~ performed electronically and telephonically.

Home~~-~~and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). ~~Starting i~~In April 2020 all CBAS ~~M~~member and facility clinical reviews and medical necessity visits were suspended due to the ~~COVID-19~~COVID-19 PHE- health emergency. -All clinical and medical necessity review is now ~~being~~ performed electronically and telephonically.
- MSSP: Home~~-~~and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020 all MSSP ~~M~~member and facility clinical reviews and medical necessity visits were suspended due to the ~~COVID-19~~COVID-19 PHE health emergency. -All clinical and medical necessity review is now ~~being~~ performed electronically and telephonically.
-

Behavioral Health Services

Medi-Cal

CalOptima ~~is responsible for providing~~offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. ~~Behavioral Health (BH)~~ S~~s~~ervices include, but are not limited to,~~:~~ individual and group psychotherapy, ~~psychology,~~ psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima also covers Alcohol Misuse Screening and Counseling (AMSC) services provided to members 18 and older in the primary care setting.

~~In addition,~~ CalOptima covers medically necessary behavioral health treatment (BHT) for members 20 years ~~years of age~~ and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)~~that meet medical necessity criteria~~. BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. ~~are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.~~

~~CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) (formerly Screening, Brief Intervention, and Referral to Treatment [SBIRT]) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.~~

~~CalOptima members can access~~ Most mental health services ~~directly, without~~do not require a physician referral. Members may access mental health services, by ~~contacting~~ calling the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be ~~referred to~~offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

~~CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.~~

CalOptima directly manages all administrative functions of the Medi-Cal ~~mental~~ behavioral health benefits including UM, claims, provider network credentialing ~~the provider network~~, member services and QI.

OC and OCC

~~CalOptima previously contracted with Magellan Health Inc., to directly manage the BH benefits for OC and OCC members. Effective 1/1/2020, OC and OCC covered BH services were fully integrated within CalOptima internal operations. OC and OCC members can access BH services by calling the CalOptima Behavioral Health Line. Members will be connected to CalOptima representative for BH assistance.~~

~~CalOptima offers AMSC services in the PCP setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.~~

CalOptima offers the following mental health services to OC and OCC members:

- Outpatient mental health care including but not limited to individual and group psychotherapy, medication management, psychological testing, intensive outpatient program (IOP), and partial hospitalization program (PHP)~~;~~.
- Inpatient mental health care in either a psychiatric or general hospital.
- Opioid Treatment Program (OTP) services~~; and~~.
- Alcohol Misuse Screening and Counseling (AMSC) services.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the OC and OCC behavioral health benefits including UM, claims, provider network credentialing ~~the provider network~~, member services and QI.

~~LINKAGES WITH COMMUNITY RESOURCES~~

~~IN ADDITION, CALOPTIMA PROVIDES LINKAGES WITH COMMUNITY PROGRAMS TO MEMBERS WITH SPECIAL HEALTH CARE NEEDS, OR HIGH RISK OR COMPLEX MEDICAL AND DEVELOPMENTAL CONDITIONS. THESE LINKAGES ARE ESTABLISHED THROUGH SPECIAL PROGRAMS, SUCH AS THE CALOPTIMA COMMUNITY LIAISONS, PCCS, BH INTEGRATION (BHI), LTSS AND SPECIFIC PROGRAM CONTRACTS AND MOUS WITH OTHER COMMUNITY AGENCIES AND PROGRAMS, SUCH AS THE OC HCA'S CCS, ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH, AND THE REGIONAL CENTER OF ORANGE COUNTY. THE UM STAFF AND DELEGATED ENTITY PRACTITIONERS ARE RESPONSIBLE FOR IDENTIFICATION OF SUCH CASES, AND COORDINATION OF REFERRAL TO APPROPRIATE STATE AGENCIES AND SPECIALIST CARE WHEN THE BENEFIT COVERAGE OF THE MEMBER DICTATES. THE UM DEPARTMENT COORDINATES ACTIVITIES WITH THE CASE MANAGEMENT DEPARTMENT TO ASSIST MEMBERS WITH THE TRANSITION TO OTHER CARE, IF NECESSARY, WHEN BENEFITS END. THIS MAY INCLUDE INFORMING THE MEMBER ABOUT WAYS TO OBTAIN CONTINUED CARE THROUGH OTHER SOURCES, SUCH AS COMMUNITY RESOURCES.~~

AUTHORITY, BOARD~~S OF~~ OF DIRECTORS' COMMITTEES, ~~AND~~ AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC)~~——~~which oversees the functions of the QI Committee described in CalOptima's ~~S~~state and ~~F~~federal Contracts~~——~~and to CalOptima's Chief Executive Officer (CEO), as ~~discussed~~ described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and

~~review and~~ make recommendations to the Board regarding ~~accepting~~ the overall QI Program. QAC ~~and annual evaluation, and~~ routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and ~~improvements achieved~~ ~~Q~~quality performance results. The QAC also makes recommendations to the B~~b~~oard for annual approval with modifications and appropriate resource allocations of the QI Program ~~and actions~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preven~~ta~~tive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons medical safety net
- ~~OC HCA~~
- Orange County Social Services Agency (~~OC~~ SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions held by ~~OC~~ HCA and ~~OC~~ SSA are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)

- CBAS provider representative
- Home-- -and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - ~~OC HCA, Behavioral Health~~
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent ~~a~~ the broad provider community that serves CalOptima members. The PAC ~~is comprised of~~has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of ~~OC~~ HCA, which maintains a standing seat. PAC meets at least quarterly and is~~are~~ open to the public. The 15 seats include:

- Health networks~~N~~
- Hospitals
- Physicians (three~~3~~ seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- ~~OC~~ HCA (one~~1~~ standing seat)
- LTSS (LTC facilities and CBAS) (one~~2~~ seat~~s~~)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

~~In 2018, CalOptima's Board of Directors established the~~ Whole-Child Model Family Advisory Committee (WCM FAC), ~~i~~as has been required by the state as part of California Children's Services (CCS) ~~when~~since it becam~~e coming~~ a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: ~~7–9~~seven to nine seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are ~~a~~ current recipients of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: two~~2~~ to four~~4~~ seats
  - Community-based organizations; or
  - Consumer advocates

Members of the c~~C~~ommittee shall serve staggered two-year terms. ~~Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term.~~ WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director, ~~of~~ Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the s~~S~~tate and f~~F~~ederal c~~C~~ontracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO), ~~along with the Deputy Chief Medical Officer (DCMO)~~ oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO oversees the strategies, programs, ~~policies~~policies, and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services ~~and Supports~~ (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (ED ~~of~~ CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED ~~of~~ CO serves as a member of the executive team, and, with

the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED ~~of~~ CO is expected to anticipate, continuously improve, ~~communicate~~communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Executive Director, Quality & Population Health Management (ED ~~of~~ Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED ~~of~~ Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED ~~of~~ Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Medical Director, Utilization Management is appointed by the CMO and/or DCMO~~,~~ and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program. The medical director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The M~~m~~edical D~~d~~irector ~~of~~ UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral health care practitioner in the QI and UM programs who~~,~~ ~~and s~~serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OC and OCC), MLTSS programs~~,~~ and Case Management ~~and Transitions of Care~~ programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The

medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, -disease management and health education programs, while also providing clinical quality oversight of the PACE Center.

Director, Utilization Management
~~Director~~ is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. -This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. -The incumbent will have oversight of CalOptima's U~~tilization~~ M~~anagement~~ program for CalOptima Community Network, CalOptima Direct and the delegated ~~health network~~HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Services (Integration) is responsible for the planning, organization monitoring and evaluation of all activities and personnel engaged in the BH UM program~~provides operational oversight for BH benefits and services provided to members~~. The director ~~is responsible for monitoring~~ tracks, ~~, analyzing~~analyzes, and reports~~ing~~ to senior staff on changes in the behavioral health care delivery environment and program

o~~o~~pportunities affecting or available to assist CalOptima in integrating physical and BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Behavioral Health Services (Clinical Operations) is responsible for the day-to-day operation of the BH UM program. The director oversees a team of care managers, medical case managers~~,~~ and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED ~~of~~ Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole~~--~~

person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure that CalOptima and its subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and ~~L~~legal ~~C~~counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical

guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years ~~of~~ managed care experience preferred.
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in U~~tilization~~ M~~anagement~~ activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN license or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years ~~of~~ managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted California Board LVN or CA RN license.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience.
- Excellent analytical and communication skills required.

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum ~~of~~ 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum ~~of~~ 2 years of college preferred.
- 2 years ~~of~~ related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum ~~of~~ 2 years of college preferred.
- 2–3 years previous administrative experience preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

- **Monitoring Nurses – UM (Medical Care Manager (LVN)** provide monitoring of referrals and specific UM initiatives to ensure compliance with UM requirements. -Monitoring activities include inpatient and outpatient, WCM, findings on Correction Action Plans (CAPs) from both internal and external audits, as well as identify opportunity for improvement when identified during the monitoring process.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum ~~of~~ 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, ~~including, but not limited to, the contract with the third-party auditor,~~ and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima ~~D~~delegated ~~H~~health ~~P~~plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T)~~,~~ Committee~~.~~, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years~~'~~ experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development

and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in ~~the~~ CalOptima ~~HNs~~ ~~D~~delegated ~~H~~health ~~P~~plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years ~~of~~ experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health care with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health

networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience & Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, ~~NCQA standards,~~ and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience & Education

- A current and unrestricted RN license or LVN license in the State of California.
- Minimum ~~of~~ 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, LTSS is responsible for assisting the LTSS management with the day-to-day operations~~,~~ of the LTSS ~~D~~department~~s~~, specifically with regard to operational and regulatory reports. The incumbent will: (1) lead collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, ~~Long Term Care~~LTC Nursing Facilities, ~~Multi-Purpose Senior Services Program~~MSSP and the ~~In-Home Support Services~~IHSS ~~P~~program to meet regulatory compliance procedures; (2) work with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; (3) gather and validate LTSS data to submit for DHCS reporting requirements and CalOptima Q~~uality~~ I~~mprovements~~ Program; (4) work with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; (5) support long-~~-~~term departmental sustainability efforts; and (6) all other activities related to the development and implementation of the LTSS program.

~~responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. This position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.~~

Experience & Education

- Bachelor's degree in Sociology, Psychology, or Gerontology is required.
- Master's degree in Social Work, Public Health, Gerontology, Health Care Administration, Public Policy, or other related field preferred.
- 5+ years of program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers, LTC ~~F~~facilities and community events.

- ~~Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.~~
- ~~Minimum of 3 years CBAS and program development experience.~~
- ~~Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.~~
- ~~Previous work experience in managing programs and building relationships with community partners is preferred.~~
- ~~Excellent interpersonal skills.~~
- ~~Computer literacy required.~~
- ~~Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).~~

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is

preferred.
- 4 years ~~of~~ supervisor or manager level experience required.
- 1 year experience in behavioral health audits (including CMS, DHCS, Department of Managed Health Care [DMHC] and NCQA).
- 1-year experience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services (Integration), Medical Director, ~~of~~ Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education
- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years of experience working in a managed care environment, with specific experience in BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.
- 2 years ~~of~~ experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years ~~of~~ experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3 or more years of supervisor level experience in clinical management of ABA services is required.
- 3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

Medical Case Managers (BH-RN) are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers~~MCMs~~ adhere to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity and consult with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, ~~utilization management~~UM criteria, and related policies/procedures for authorization and referral requests from B~~ehavioral H~~ealth and ABA providers.~~clinical review and recommendations related to Interdisciplinary Care Team (ICT)~~

~~meetings, inpatient and outpatient psychiatric authorization requests from BH providers and completing inpatient CCR and transitional care for OC and OCC members. They are responsible for adhering to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity, consulting with the manager and Medical Director as needed. They also review prior authorization requests for outpatient mental health services.~~

Experience & Education

- Current and unrestricted RN license to practice in the State of California
- Minimum ~~of~~ 3 years current BH clinical experience or an equivalent combination of education and experience required.
- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes medical criteria, and policies~~,~~ and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers

Experience & Education

- High school diploma required, Associates or Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years ~~of~~ clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in B~~ehavioral H~~~~ealth~~ or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4 or more years providing ABA therapy to children diagnosed with ASD is required.
- Experience in clinical, medical utilization review, and/or quality assurance is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language~~s~~ is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in ~~behavioral health~~BH or related field is preferred.
- 2 years ~~of~~ experience in ~~behavioral health~~BH, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.

Qualifications and Training

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation~~.~~
- HIPAA and Privacy/Corporate Compliance~~.~~
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)~~.~~
- UM Program, policies/procedures, etc.
- MIS data entry~~.~~
- Application of Review Criteria/Guidelines~~.~~
- Appeals Process~~.~~
- Seniors and Persons with Disabilities Awareness Training~~.~~
- OC and OCC Training

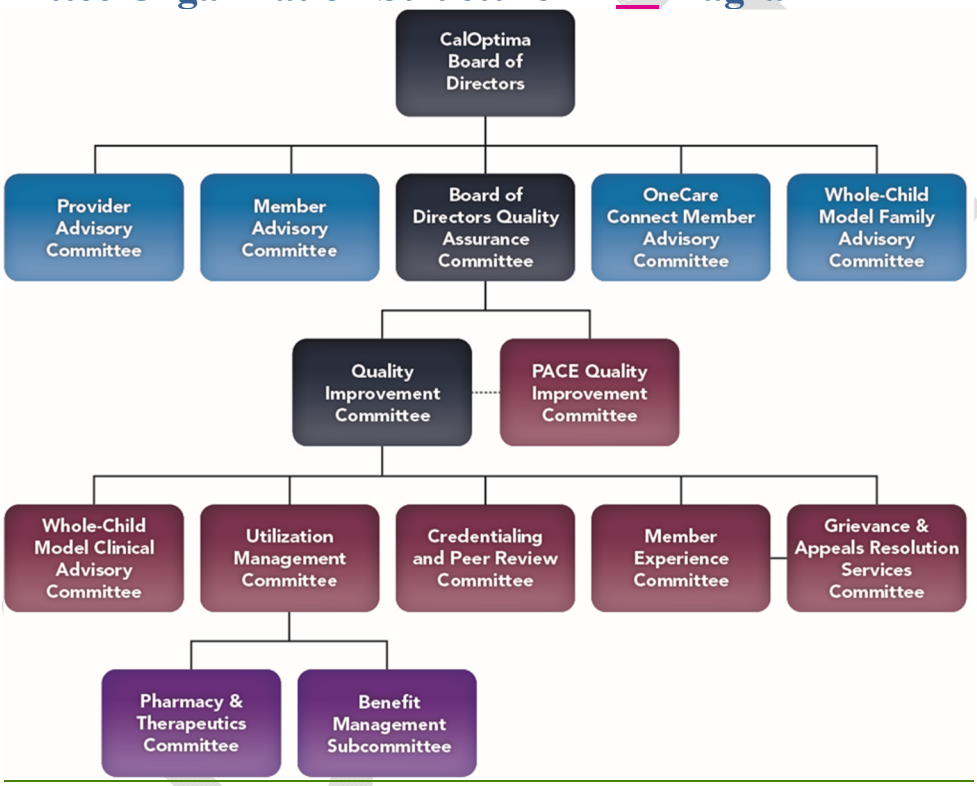
CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of ~~-~~the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. ~~-~~The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to

perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff ~~is~~ are required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2020 Committee Organization Structure Diagram



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources,

and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up to QIC and ultimately to- QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals
  - UM Workgroup
  - LTSS

- Reports to the QIC on a quarterly basis; communicates significant findings and makes

recommendations related to UM issues.

UMC Membership
Voting Members:

- CMO
- Medical Director UM
- Medical Director Behavioral Health
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists~~,~~ and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Medical Director, Whole~~ ~~Child Model
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, ~~Operational Instruction Letters (OILs),~~ Medi-Cal Managed Care Division (MMCD), national and local coverage determinations, All Plan Letters (APLs)~~,~~ and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility ~~of~~ for the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director, Utilization Management~~——~~Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) UM Director in conjunction with the Executive Director ~~of~~ Clinical Services, Chief Medical Officer, and Deputy Chief Medical Director ~~and Utilization Management Medical Director~~ prior to submission for committee review and approval.
- Utilization data, ~~is collected, aggregated, and analyzed~~ including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization. Is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, ~~Managed~~ LTSS Programs, P&T, QI, Credentialing, Compliance~~,~~ and Audit ~~and~~ & Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC, or who otherwise make decisions on UM~~,~~ and quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests~~,~~ file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees~~,~~ including contracted professionals who have access to confidential or member information~~,~~ sign a written statement delineating responsibility for maintaining confidentiality. In addition, all c~~C~~ommittee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member~~,~~ or practitioner~~,~~ specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs~~,~~ and SRGs ~~and~~ hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM PROCESS

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit ~~and~~ & Oversight department via its delegation oversight team for compliance.

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances, relative to appropriate clinical criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of available services within the local delivery system on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means all covered services or supplies that:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with the member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r)~~®~~ and California Welfare and Institutions Code sections 14132(v).
- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for ~~health network~~HN members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, and regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508:~~,~~ Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor

Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.

- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer) or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions,

elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website ~~at www.caloptima.org. .~~Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of~~-~~-network practitioners.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis~~, or~~ options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of~~-~~-network practitioner~~,~~ if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "~~Standing Referral"~~CalOptima policy and procedure, GG.1112: Standing Referral~~-~~ to Specialist Practitioner or Specialty Care Center~~: GG.1112~~, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health

practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.
CalOptima distributes an affirmative- statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the ~~CalOptima Approved Drug List~~ OneCare/Connect (OC/OCC) ~~(~~Formulary~~)~~, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the ~~CalOptima Approved Drug List~~Formulary are communicated to both members and providers. ~~If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:~~

- ~~No formulary alternative is appropriate, and the drug is medically necessary.~~
- ~~The member has failed treatment or experienced adverse effects on the formulary drug.~~
- ~~The member's treatment has been stable on a non-formulary drug and change to a formulary drug is medically inappropriate.~~

~~To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a pharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a clinical pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review~~

Pharmacy Determinations

~~Medi-Cal~~

Medi-Cal

It is expected that, e~~E~~ffective April 1, 2021, the outpatient pharmacy benefit will move to the Medi-Cal fee-for-service program.

~~**CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the P&T. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima pharmacist or Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima pharmacist or Medical Director. CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:**~~

- ~~**A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.**~~
- ~~**An explanation of the appeal process, including the appeal time frames and the member's right to representation.**~~
- ~~**A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.**~~
- ~~**Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.**~~

~~**CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.**~~

OC/OCC

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

~~**Formulary**~~

~~The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the P&T. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.~~

Pharmacy Benefit Manager (PBM)

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, the pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services, and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit ~~and~~ & Oversight department's policies and procedures.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal

CalOptima's BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, ~~Department of Health Care Services~~DHCS

All Plan Letters (APLs), and CalOptima policy (approved by DHCS).

OC/OCC

CalOptima has previously delegated Magellan Health Inc. to directly manage the ~~behavioral health~~BH ~~utilization management~~UM functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's BHI department ~~will~~ performs~~ed~~ prior authorization review functions for OC/OCC covered ~~behavioral health~~BH services. Services that require prior authorization include inpatient psychiatric care, the partial hospitalization program, the intensive outpatient program, ~~,~~ and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPLs), and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed~~-~~ CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM CRITERIA

CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence~~-~~ based standards of care ~~and~~ that include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

–Medi-Cal

1. Federal and State Law Mandates (i.e. Department of Health Care Services – Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
    a. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

2. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

3. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
    a. https://www.uspreventiveservicestaskforce.org/
    b. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and ~~county~~ CCS Program Information Notices for decisions related to CCS and Whole-Child Model.
    a. https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

2. Follow Medi-Cal hierarchy listed above.

~~1. Medi-Cal~~

~~**Federal and state law mandates (i.e. CMS, DHCS)**~~

~~**Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines**~~

~~**EPSDT**~~

~~**Nationally recognized evidence based criteria such as Milliman Care Guidelines (MCG),** U.S.**Preventative Services Task Force recommendations and National Comprehensive Cancer Guidelines, etc.**~~

~~**Transplant Centers of Excellence guidelines**~~

~~**Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology [ACOG] Guidelines,**~~

~~American Medical Association (AMA) and National Guidelines Clearinghouse)~~

~~CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines~~

~~Whole Child Model~~

~~In addition to the Medi-Cal hierarchy above:~~

~~CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.~~

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates –-CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
        i. https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

2. Department of Health Care Services
    a. Medi-Cal Provider Manual
    b. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

3. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

4. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
    a. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

~~1.~~ ~~Medicare~~

~~For OC and OCC:~~

~~1. Federal and state law mandates (i.e. CMD, DHCS)~~
~~2. CMS Guidelines Local and National Coverage Determinations (LCD, NCD)~~
~~3. Medicare Part D: CMS-approved Compendia (for medications)~~
~~4. Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines~~
~~5. Nationally recognized evidence based criteria such as MCG, UpToDate, U.S. Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.~~
~~6. Transplant Centers of Excellence guidelines~~
~~7. Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, ACOG Guidelines, AMA, National Guidelines Clearinghouse)~~
~~8. CalOptima Criteria for outpatient behavioral health services~~
~~9. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines~~

Delegated HNs must utilize Medi-Cal & ~~the same or similar nationally recognized criteria~~Medicare Guidelines, Title ~~XX~~22 of the California Code of Regulations, and national evidenced based guidelines.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse Reviewer**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually / Medi-Cal and Medicare Manuals / CalOptima Pharmacy– – Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient Hhospital Sservices	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X

Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters for WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination.
** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	X		X
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may also be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on a~~n~~ UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

~~**New Technology Review**~~

~~The P&T and BMSC shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.~~

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies ~~with regard to~~regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action.

New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the Ceommittee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number, **888-587-8088**, at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at ~~800-735-2929~~711. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday ~~–~~ Friday are responded to on the same business day.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima. In cases requiring immediate response the vendor staff notifies CalOptima on-call nurse. CalOptima will review and process authorizations outside business hours, as necessary, including decisions to deny or modify authorization requests which are made by CalOptima on-call UM physician~~or notifies CalOptima on-call nurse in cases requiring immediate response~~. A log is forwarded by the vendor to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer
The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise
The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors~~, with the support of the UMC,~~ have the authority, accountability, and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records
During prospective and concurrent telephonic review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to

conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, ~~disease management~~PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical ~~care~~care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options~~;~~.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective ~~or concurrent~~ service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "All information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the 72 hours expedited period to 14 calendar days if the ~~M~~member requests an extension, or if the plan justifies a need. ~~may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:~~ ~~▪ Within 24 hours of receipt of the urgent preservice request~~	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	~~The plan gives the member or member's authorized representative at least 48 hours to provide the information.~~		**Member:** Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination (written notification) **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.
	▪ ~~The extension period, within which a decision must be made by the plan, begins:~~ ○ ~~On the date when the plan receives the member's response (even if not all of the information is provided), *or*~~ ○ ~~At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.~~ **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations:	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	○ The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. ○ Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a decision (NCQA UM 5). ○ A response to defer is required within 24 hours for all services that require prior authorization.	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		~~permitted under Title 42, CFR, Sections 431.213 and 431.214.~~
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified **Member & Practitioner**: None specified **Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
Hospice — Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

Medicare ~~(Excludes Pharmacy Requests)~~

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later than upon expiration of extension.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	~~than upon expiration of extension.~~

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal	OC and OCC
Processed by CalOptima Pharmacy Management department or Pharm Benefits Manager	Processed by CalOptima Pharmacy Management department

Medi-Cal	OC and OC C

Standard (Non-urgent) Preservice: Within 24 hours a decision to appro modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed: Within 5 workin days of receiving needed informatio but no longer than 14 calendar days** **Expedited (Urgent) Preservice/Concurrent: Within 24 h a decision to approve, modify, deny**	**Routine: 72 hours** **Urgent: 24 hours** **Retrospective: 14 days**

Medi-Cal	OC and OCC
Pre-Service and Concurrent Appro Provider: Electronic/written: Withi hours of making the decision. Pre-Service and Concurrent Denial Provider: Electronic/written: Withi hours of making the decision. Member: Written: Within 2 busines days of making the decision. Post Service/ Retrospective Approv Practitioner: Written: Within 30 da of receipt of request. Post Service/ Retrospective Denials:	Authorization Request Type: For expedited requests: Written notification must be provid to the member within 24 hours fron receipt of the request. If initial notification is made orally, then wri notification must be provided withi calendar days of the oral notificatio For standard requests: Written notification must be provid to the member within 72 hours fron receipt of the request. If initial notification is made orally, then wri notification must be provided withi calendar days of the oral notificatio For retrospective requests: Written notification must be provid to the member within 14 calendar d

2021
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Back to Agenda Back to Item

2021 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

Andrew Do **Date**

TABLE OF CONTENTS

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members is in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry- recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members'

health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures**,** including providing opportunities for stakeholder input.
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services
Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs
To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OneCare (OC) to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare , CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi- Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community- based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)

COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy. Additionally, UM requirements for COVID PHE screening, vaccinates and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. WPC is scheduled to terminate December 31, 2020, however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicare Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely**.** Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC, who are also eligible for the HHP, to continue with their current WPC providers for their housing- related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the county. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with Whole-Person Care and Board of Director's authorization to extend the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole Person Care program. The grant funds have been exhausted.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 PHE, these services are available via telehealth, in addition to in person.
- Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. CalOptima provides preventive screenings, chronic care, care coordination and follow up.
- Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

Effective April 1, 2021, the Department of Health Care Service (DHCS) is carving out the outpatient

pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/ prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect the OneCare or OneCare Connect and lines of business and PACE Program.

Virtual Care Strategy

In 2021, federal and state rules and regulations provided limited waivers for telehealth due to the COVID-19 PHE, that enabled CalOptima to accelerate its virtual care strategy under COVID-19 PHE shelter-at-home measures. Members were able to receive appropriate health care services through telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.
2. Leverage existing delivery model where possible.
3. Be proactive in seeking out opportunities to innovate.
4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 20210 are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member - focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma- Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals

- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, will be developed and implemented.

With Whom We Work

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs providing health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs, representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for members to select, supplementing the HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	

AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on Medical Necessity and/or benefit coverage.
- Identify and refer high-risk members to Case Management programs, including Complex Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate practitioners and other providers, including delegated HNs on CalOptima's UM Program, policies and procedures on an ongoing basis.
- Monitor utilization practice patterns of practitioners to identify variations from the standard

practice that may indicate need for additional education or support.
- Continuous identification of UM staff needs, and appropriate training delivered to address those needs, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality- based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:
- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs' UM activities by the Audit and Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for

Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

LONG-TERM SUPPORT SERVICES

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- In April 2020, all LTC member facility clinical reviews and medical necessity nursing facility visits were suspended due to the COVID-19 PHE. All clinical review is now performed electronically and telephonically.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). In April 2020 all CBAS member and facility clinical reviews and medical necessity visits were suspended due to the Public Health Emergency COVID-19PHE All clinical and medical necessity review is now performed electronically and telephonically.
- MSSP: Home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020 all MSSP member and facility clinical reviews and medical necessity visits were suspended due to the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.

Behavioral Health Services

Medi-Cal
CalOptima offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Services include but are not limited to individual and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima also covers Alcohol Misuse Screening and Counseling (AMSC) services provided to members 18 and older in the primary care setting.

CalOptima covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

Most mental health services do not require a physician referral. Members may access mental health services, by calling the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

OC and OCC
CalOptima offers the following mental health services to OC and OCC members:

- Outpatient mental health care including but not limited to individual and group psychotherapy, medication management, psychological testing, intensive outpatient program (IOP), and partial hospitalization program (PHP).
- Inpatient mental health care in either a psychiatric or general hospital.
- Opioid Treatment Program (OTP) services.
- Alcohol Misuse Screening and Counseling (AMSC) services.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the OC and OCC behavioral health benefits including UM, claims, provider network credentialing , member services and QI.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's state and federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support

- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons — medical safety net
- Orange County Social Services Agency (SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs — behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee
The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - SSA
    - OC Community Resources Agency, Office on Aging
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
Whole-Child Model Family Advisory Committee (WCM FAC), has been required by the state as part of California Children's Services (CCS) when it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: seven to nine seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: two to four seats
    - Community-based organizations; or
    - Consumer advocates

Members of the committee shall serve staggered two-year terms. WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several

departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO), oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO oversees the strategies, programs, policies, and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Medical Director, Utilization Management is appointed by the CMO and/or DCMO and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program. The medical director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the

bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral health care practitioner in the QI and UM programs who serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OC and OCC), MLTSS programs and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's UM program for CalOptima Community Network, CalOptima Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Services (Integration) is responsible for the planning, organization monitoring and evaluation of all activities and personnel engaged in the BH UM program. The director tracks, analyzes, and reports to senior staff on changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Behavioral Health Services (Clinical Operations) is responsible for the day-to-day operation of the BH UM program. The director oversees a team of care managers, medical case managers and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure that CalOptima and its subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and legal counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.

- A Bachelor’s degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor’s degree or relevant experience in a health care field preferred.
- 3 years managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor’s degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN license or LVN license in the State of California.

- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education
- Current and unrestricted California Board LVN or CA RN license.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience.
- Excellent analytical and communication skills required.

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- Current and unrestricted California Board LVN or RN license.
- Minimum 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- High school graduate or equivalent; a minimum 2 years of college preferred.
- 2 years related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum 2 years of college preferred.
- 2–3 years previous administrative experience preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

Monitoring Nurses – UM (Medical Care Manager (LVN)) provide monitoring of referrals and specific UM initiatives to ensure compliance with UM requirements. Monitoring activities include monitoring referrals including inpatient and outpatient, WCM, findings on Correction Action Plans (CAPs) from both internal and external audits, as well as identify opportunity for improvement when identified during the monitoring process.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics

(P&T) Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health care with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health

networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience & Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience & Education

- A current and unrestricted RN license or LVN license in the State of California.
- Minimum 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department, specifically with regard to operational and regulatory reports. The incumbent will: (1) lead collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, LTC Nursing Facilities, MSSP and the IHSS program to meet regulatory compliance procedures; (2) work with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; (3) gather and validate LTSS data to submit for DHCS reporting requirements and CalOptima QI Program; (4) work with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; (5) support long-term departmental sustainability efforts; and (6) all other activities related to the development and implementation of the LTSS program.

Experience & Education

- Bachelor's degree in Sociology, Psychology, or Gerontology is required.
- Master's degree in Social Work, Public Health, Gerontology, Health Care Administration, Public Policy, or other related field preferred.
- 5+ years of program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers, LTC facilities and community events.

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is preferred.
- 4 years supervisor or manager level experience required.
- 1 year experience in behavioral health audits (including CMS, DHCS, Department of Managed Health Care [DMHC] and NCQA).
- 1-year experience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services (Integration), Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education

- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years of experience working in a managed care environment, with specific experience in BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.

- 2 years experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3 or more years of supervisor level experience in clinical management of ABA services is required.
- 3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

Medical Case Managers (BH-RN) are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers adhere to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity and consult with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, UM criteria, and related policies/procedures for authorization and referral requests from BH and ABA providers.

Experience & Education
- Current and unrestricted RN license to practice in the State of California
- Minimum 3 years current BH clinical experience or an equivalent combination of education and experience required.
- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes medical criteria, and policies and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers

Experience & Education
- High school diploma required, Associates or Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in BH or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4 or more years providing ABA therapy to children diagnosed with ASD is required.
- Experience in clinical, medical utilization review, and/or quality assurance is preferred.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in BH or related field is preferred.
- 2 years experience in BH, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.

Qualifications and Training

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

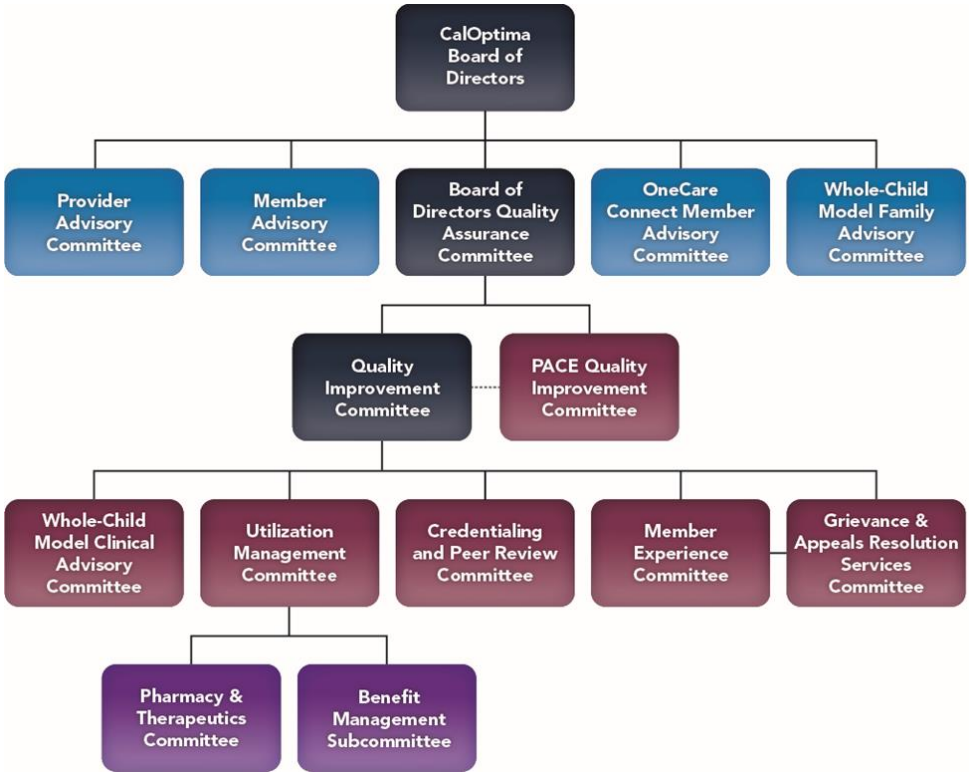
- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training
- OC and OCC Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff are required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2021 Committee Organization Structure — Diagram



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up to QIC and ultimately to QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM program,

consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HNs.

- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals
  - UM Workgroup
  - LTSS

- Reports to the QIC on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

UMC Membership

Voting Members:

- CMO
- Medical Director UM
- Medical Director Behavioral Health
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Medical Director, Whole-Child Model
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director, Utilization Management — Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.

- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, LTSS Programs, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs and SRGs hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM PROCESS

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit & Oversight department via its delegation oversight team for compliance.

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances appropriate clinical criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of available services within the local delivery system on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means all covered services or supplies that:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d® and California Welfare and Institutions Code sections 14132(v).
- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided

health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508: Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.

- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer) or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the

CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of- network practitioners.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "CalOptima policy and procedure, GG.1112: Standing Referral to Specialist Practitioner or Specialty Care Center, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and

professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.
CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Pharmaceutical Management

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the OneCare/Connect (OC/OCC) Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations

Medi-Cal
Effective April 1, 2021, the outpatient pharmacy benefit will move to the Medi-Cal fee-for-service program.

OC/OCC
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal
CalOptima's BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers

and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, DHCS All Plan Letters (APL), and CalOptima policy (approved by DHCS).

OC/OCC
CalOptima has previously delegated Magellan Health Inc. to directly manage the BH UM functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's BHI department performed prior authorization review functions for OC/OCC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL), and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM Criteria

CalOptima conducts Utilization Review using UM criteria for medical, BH, and pharmacy medical necessity decisions that are nationally recognized, evidence- based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

Medi-Cal

1. Federal and State Law Mandates (i.e. Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
   a. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

2. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
   a. https://www.nccn.org/professionals/physician_gls/default.aspx

3. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
    a. https://www.uspreventiveservicestaskforce.org/
    b. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole-Child Model.
    a. https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

2. Follow Medi-Cal hierarchy listed above.

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates - CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
        i. https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

2. Department of Health Care Services
    a. Medi-Cal Provider Manual
    b. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

3. National Evidence-Based Guidelines (e.g. MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

4. Society Guidelines (e.g. American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
    a. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Delegated HNs must utilize Medi-Cal & Medicare Guidelines, Title 22, and national evidenced based guidelines.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse Reviewer**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient Hospital Services	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X

Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters for WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals//CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria and no clinical judgment is required.

** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	**X**		**X**
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for

performance below the established benchmark of 90% are discussed and recommendations taken from the Committee.

Provider and Member Communication

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **711**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima. In cases requiring immediate response the vendor staff notifies CalOptima on-call nurse. CalOptima will review and process authorizations outside business hours, as necessary, including decisions to deny or modify authorization requests which are made by CalOptima on-call UM physician. A log is forwarded by the vendor to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective and concurrent review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of

care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "All information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the 72 hours expedited period to 14 calendar days if the member requests an extension, or if the plan justifies a need.	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
			Member: Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination (written notification) **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.
	Expedited (Urgent) Pre-Service request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations: o Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or o In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. ○ Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a decision (NCQA UM 5). ○ A response to defer is required within 24 hours for all services that require prior authorization.	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request.	**Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
	Additional Information Received: If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Member & Practitioner**: None specified	
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified	
Hospice — Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

Medicare

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later than upon expiration of extension.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal	OC and OCC
Processed by CalOptima Pharmacy Management depart Pharmacy Benefits Manager Qualified pharmacist or physician review for any modif or denials Qualified physician review for any appeals	Processed by CalOptima Pharmacy Management Department Qualified pharmacist or physician review for any modifications or denials Qualified physician review for any appeals

Medi-Cal	OC and OC C
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. Standard (Non-urgent) Preservice, Extension Needed: Within 5 working days of receiving needed information, but no longer than 14 calendar days Expedited (Urgent) Preservice/Concurrent: Within 24 hours a decision to approve, modify, deny or defer is required. Expedited (Urgent) Preservice/Concurrent, Extension Needed: Within 72 hours of the initial request Post-Service/Retrospective: Within 30 days of receipt	Routine: 72 hours Urgent: 24 hours Retrospective: 14 days

Medi-Cal	OC and OCC
Pre-Service and Concurrent Approvals: Provider: Electronic/written: Within 24 hours of making the decision. Pre-Service and Concurrent Denials: Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 2 business days of making the deci Post Service/ Retrospective Approvals: Practitioner: Written: Within 30 days of receipt of request. Post Service/ Retrospective Denials: Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of receipt of request.	Authorization Request Type: For expedited requests: Written notification must be provided to the member within 2 from the receipt of the request. If initial notification is made o then written notification must be provided within 3 calendar d the oral notification. For standard requests: Written notification must be provided to the member within 7 from the receipt of the request. If initial notification is made o then written notification must be provided within 3 calendar d the oral notification. For retrospective requests: Written notification must be provided to the member within 1 calendar days from the receipt of the request. If initial notifica made orally, then written notification must be provided within calendar days of the oral notification.

Emergency Services

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A non-contracted hospital must submit a Prior Authorization Request for Post-Stabilization Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) do not apply to contracted providers relative to CalOptima's Medi-Cal Program. CalOptima or a HN shall approve or deny a prior authorization request for post- stabilization services and all information reasonably necessary and requested to render a decision from a non-contracted hospital within 30 minutes after receiving such request and information for Medi-Cal members, and within 60 minutes after receiving such request and information from a non-contracted hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed time frame, medically necessary post-stabilization inpatient services are considered approved.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior

authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director UM, or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

Facilities are required to notify CalOptima of all inpatient prior-authorized admissions within 1 business day following the actual admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each

hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial, or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in CalOptima Policy GG.1508: Authorization and Processing of Referrals. The written notification is written in lay language that is easily understandable at the 6th grade level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

Grievance and Appeal Process

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OC C members wish to exercise their right to review the UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the

termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

Long-Term Services and Supports

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A, NF-B, sub-acute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: Onsite NFs where CalOptima nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when a member needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at

center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP
CalOptima has responsibility for the payment of MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

TRANSITIONS OF CARE

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from acute care hospitals (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the current Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are

managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM, the Clinical Performance Excellence Committee, identified stakeholders and reported to UMC. The UMC reviews the Over/Under Utilization Dashboard on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization. Over and Under Utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed days
- Admits per 1000
- Average length of stay
- Readmission rates
- Denial rates
- Pharmacy utilization measures
- Appeal overturn rates — provider per 1000 per year

- Member grievances per thousand
- Outliers from Fraud, Waste & Abuse investigations
- Select HEDIS rates for selected measures
- PCP & specialist referral pattern analysis
- Member utilization patterns
- Trends in UM related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.
Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 25, 2021
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

8. Consider Recommending Board of Directors Approval of Modifications to Quality Improvement Policies

Contacts

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

Recommend that the Board of Directors approve modifications to the following CalOptima policies pursuant to CalOptima's annual review process:

- GG.1603: Medical Records Maintenance
- GG.1611: Potential Quality Issue Review Process
- GG.1615: Corrective Action Plan for Practitioners
- GG.1658: Suspend, Restrict or Terminate Practitioner Participation in CalOptima's Network

Background/Discussion

Modifications to Existing Quality Improvement Policies and Procedures and New GG.1658
CalOptima regularly reviews its policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima operations.

The following Quality Improvement policies require modifications:

- ***GG.1603: Medical Records Maintenance [Medi-Cal, OneCare, OneCare Connect]*** defines the minimum standards for maintaining a Member's Medical Records. CalOptima staff revised this policy pursuant to the CalOptima annual review process and includes revised language to align with 2020 DHCS Medical Record Review Standards, added additional APL references, regulatory codes, medical record definition, and line of business definitions. Primary care practitioner and telehealth definitions were also modified.
- ***GG.1611: Potential Quality Issue Review Process [Medi-Cal, OneCare, OneCare Connect]*** defines the process for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Quality Improvement (QI) department. CalOptima staff revised this policy pursuant to the CalOptima annual review process, and added specificity to time frames for reviews, medical record response from provider, and target to close cases. Staff also added clarity regarding cases that are submitted anonymously, and updated several letters that were attached to the policy. Revisions include incorporation of PQI leveling definitions from policy GG.1612 into GG.1611. Once incorporated, GG.1612 will be retired.

Back to Agenda

- ***GG.1615: Corrective Action Plan for Practitioners [Medi-Cal, OneCare, OneCare Connect and PACE]*** defines the appropriate action process that CalOptima shall use for practitioners, including routine monitoring, investigation, and corrective action related to their clinical practice. CalOptima staff revised this policy to better define how practitioners are monitored, investigated and how appropriate action is taken for non-medical and medical disciplinary causes or reasons. A new policy (GG.1658) was developed from GG.1615 to address summary suspensions or restrictions for medical disciplinary cause or reason. In the procedure section, a section was added to include non-medical disciplinary corrective actions which are not reportable, and a section to address medical disciplinary causes or reasons which references new policy GG.1658.
- ***GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network [Medi-Cal, OneCare, OneCare Connect and PACE]*** is a new policy that defines the process CalOptima uses to impose a summary suspension or restriction on a practitioner for a medical disciplinary cause or reason. GG.1658 was developed to address summary suspensions and restrictions for medical disciplinary cause or reason.

Fiscal Impact
The recommended action to approve revisions to CalOptima Policies GG.1603, GG.1611, GG.1615 and GG.1658 is operational in nature and is not expected to have any fiscal impact.

Rationale for Recommendation
The recommended action will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policies will supersede the prior versions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. GG.1603: Medical Records Maintenance Final Policy Packet
2. GG.1611: Potential Quality Issue Review Process Final Policy Packet
3. GG.1615: Corrective Action Plan for Practitioners Final Policy Packet
4. GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network Final Policy Packet

/s/ Richard Sanchez — *02/17/2021*
Authorized Signature — **Date**

Back to Agenda

Policy #: GG.1603
Title: **Medical Records Maintenance**
Department: Medical ~~Affairs~~Management
Section: Quality Improvement

CEO Approval: ~~Michael Schrader~~ _____

Effective Date: 10/01/1995
Revised Date: ~~03/01/2019~~ TBD

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

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's~~*~~ Medical Records.

II. POLICY

A. A Practitioner and Provider shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

Back to Agenda
Back to Item
~~* Terms in **bold** are defined in the Glossary~~

b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable; ~~and~~

viii. ~~Preferred~~Primary language~~,~~ and linguistic service needs~~, and the request~~ of non-or ~~refusal of~~limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language ~~assistance~~and/or interpretation services by a non-or limited-English proficient member are documented, as applicable. Member refusal of interpreter services may be documented at least once and be accepted throughout the Member's care, unless otherwise specified; and

~~viii.~~x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

2) Treatment;

3) Discharge instructions; and

4) Recommended follow-up.

~~i. Initial Health Assessment (IHA);~~

~~ii.~~i. ~~Initial Individualized Health Education Behavioral Assessment (IHEBA);~~

~~xiii. If a **Member** is eighteen (18) years of age or older, documentation of whether the **Member** has been informed and has executed an advance directive;~~

~~xiv. Signed consent form or statement for any invasive procedure;~~

~~ii. Authorization Request Forms (ARFs);~~

~~iii.~~ii. ~~Referrals;~~

~~iv.~~ii. ~~Significant telephone advice, documented with date, time, and signature;~~

~~xv. Consultation reports; and~~

~~xvi.~~xiii. Prescriptions.

c. Preventive Care

~~iii.~~i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

~~iv.~~ Preventive care and health maintenance services rendered;

ii.

~~v.~~ Initial Health Assessment (IHA);

iii.

~~vi.~~ Initial Individualized Health Education Behavioral Assessment (IHEBA);

iv.

~~vii.~~ Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

v.

~~viii.~~

~~ix.~~ Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

vi.

~~x.~~

vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

~~d.~~e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

~~A.~~C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal~~
~~C.~~D. CalOptima Contract for Health Care Services
~~D.~~E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
~~E.~~F. CalOptima Policy GG.1618: Member Request for Medical Records
~~F.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
G. Department of Health Care Services (DHCS) Policy Letter (PL) 99-003: Cultural and ~~Linguistic~~Linguistics
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004: Immunization Requirements
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009: Telehealth Services Policy
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006: Site Reviews: Facility Site Review and Medical Record Review
~~H.~~L. Title 22, California Code of Regulations~~,~~ (CCR), §75055
~~I.~~M. Title 28, California Code of Regulations~~,~~ (CCR), §§1300.67.1(c) and 1300.80(b)(4)
~~J.~~N. Title 42, United States Code, §1396a(w)
~~K. California Assembly Bill 1688 (Chapter 511, Section 2), Statutes of 2017)~~
O. California Welfare & Institutions Code §14124.1
P. California Probate Code §§ 4701 and 4780-4785
Q. California Business and Professions Code §2290.5
R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100
S. Standards for Determining Threshold Languages and Requirement For Section 1557 Of The Affordable Care Act (APL) 17-011

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/10/10	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

1

IX. GLOSSARY

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
Individualized Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy. OneCare / OneCare Connect: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A ~~n enrollee~~ beneficiary enrolled in ~~of~~ a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~ Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a ~~non~~Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model

Term	Definition
	beneficiaries, a PCP may also be a ~~specialists~~specialty care provider or clinic ~~in accordance with W & I Code 14182(b)(11).~~.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.
~~Provider~~Telehealth	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, health network, or other person or institution who furnishes covered services.~~The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

1

Policy #:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	10/01/1995
Revised Date:	TBD

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

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner and Provider shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

Back to Agenda Back to Item

b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable;

viii. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language and/or interpretation services by a non-or limited-English proficient member are documented, as applicable. Member refusal of interpreter services may be documented at least once and be accepted throughout the Member's care, unless otherwise specified; and

x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

2) Treatment;

3) Discharge instructions; and

4) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

iii. Initial Health Assessment (IHA);

iv. Initial Individualized Health Education Behavioral Assessment (IHEBA);

v. Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

vi. Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract for Health Care Services
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F. CalOptima Policy GG.1618: Member Request for Medical Records
G. Department of Health Care Services (DHCS) Policy Letter (PL) 99-003: Cultural and Linguistics
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
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L. Title 22, California Code of Regulations (CCR), §75055
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N. Title 42, United States Code, §1396a(w)
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R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100
S. Standards for Determining Threshold Languages and Requirement For Section 1557 Of The Affordable Care Act (APL) 17-011

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/10/10	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
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Member	A beneficiary enrolled in a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
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Term	Definition
	supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
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Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

1

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

PURPOSE

This policy defines the process for reviewing and processing of a Potential Quality Issue (PQI~~), including Quality of Care (QOC) issues,~~) referred to the CalOptima Quality Improvement (QI) Department.

POLICY

A. All CalOptima departments, Practitioners, Providers, Health Networks, and ~~HDOs~~Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the CalOptima Quality Improvement (QI) Department for review and investigation.

~~1. If a Member chooses to remain anonymous, the PQI case will be opened by QI staff and flagged as confidential.~~

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI ~~Nurses~~nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request ~~Medical Records~~medical records and/or other CalOptima records as well as pertinent documentation from Providers, ~~including but not limited to individual Primary Care Physician (PCP) offices, Health Network main offices, hospitals, Skilled Nursing Facilities (SNF), or other Health Delivery Organizations (HDOs). The QI Department shall conduct a medical review, case review, or both.~~as needed.

~~D. CalOptima shall score a PQI case in accordance with CalOptima Policy GG.1612A: Outcome Scores for Potential Quality Issues.~~

~~E.~~D. CalOptima's Chief Medical Officer (CMO~~),~~) or Designee~~,~~ shall refer PQI cases to the CalOptima Credentialing and Peer Review Committee (CPRC) for further evaluation and action, ~~as necessary, in accordance with~~pursuant to the CalOptima ~~QI Plan~~Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and HDO PQI data every six (6) months to identify emerging patterns. This data shall be reviewed by the CMO~~,~~ or Designee~~,~~ who shall report any issues and/or emerging patterns to the CalOptima CPRC for further evaluation and action, as necessary.

Back to Agenda Back to Item

F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima CPRC.

G. The CPRC shall report a summary of trends and activities ~~and findings~~ to the CalOptima Quality Improvement Committee (QIC) and to the Board of Directors' Quality Assurance Committee (QAC).

H. CalOptima shall maintain confidentiality of quality improvement case review information, in accordance this ~~policy~~Policy.

PROCEDURE

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and HDOs may identify and refer a PQI to CalOptima's QI Department.

2. A PQI may be referred from an internal CalOptima department, including but not limited to, Grievance & Appeals Resolution Services (GARS), Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management (UM) ~~Concurrent Review, and~~), Case Management and Compliance.

~~a. If a CalOptima department refers the PQI case, the department shall identify if the Member chooses to remain anonymous.~~

3. ~~All PQI referrals received shall be entered into CalOptima's care management system by QI intake staff and a quality of care (QOC) case shall be opened.~~ Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

a. ~~Upon receipt of~~ Any entity referring a PQI ~~referral,~~case, shall identify if the Member chooses to remain anonymous.

4. A QI Nurse shall perform an initial clinical review within three (3) business days and determine:

a. If the case is a Quality of Care (QOC) or Quality of Service (QOS) based on the initial information received; and

b. If the Member has any urgent clinical issues, care coordination will be provided by the QI Nurse.

B. Process, Review and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima PQI team and documented in CalOptima's care management system.

a. The CalOptima PQI team shall send an acknowledgement letter to the Member.

b. If the ~~shall~~ Member chooses to remain anonymous, the case will be flagged as confidential and no acknowledgement letter will be sent to the Member~~, and~~.

~~a.~~ If the case ~~shall be~~was not referred ~~to a QI Nurse to assess and review for potential Quality of Care (QOC) issues.~~ by

b.c. If the case is determined by the QI Nurse to be Quality of Service (QOS), the case shall be closed and a resolution letter shallMember or a Member's representative, no acknowledgement letter will be sent to the Member.

i. If the case was referred by an internal CalOptima department, notification of the QOS determination will be communicated to the referring department for educational purposes.

c. If theThe QI Nurse determines the case to be a potential QOC issue, the case will be prepared by the QI Nurse for medical review by a CalOptima Medical Director.

B. Medical Review Process

i. A CalOptima QI Nurse shall perform the QOC case review.

a.d. The CalOptima QI Departmentnurse shall request copies of pertinent Medical Recordsmedical records and a response to the Member's complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or HDO(s) that rendered medical services or were involved in rendering the medical service(s).), as needed. A Provider, Practitioner, Health Network, or HDO shall submit such records and response to the CalOptima QI Department within seven (7fourteen (14) calendar days after receipt of the request.

ii.i. If a Provider, Practitioner, Health Network, or HDO fails to respond within the required timeframe:

a) The CalOptima QI Department shall follow-up with a minimum of three (3) attempts within thirty (30) business days to obtain the requested information.

b) CalOptima may request a written and signed explanation for any delay in submitting records or responding to a request for a case review. This document shall become a permanent part of the review record.

c) If there is no reasonable or acceptable explanation provided by the Provider, Practitioner, Health Network, or HDO, or if the delay continues, CalOptima's QI Department, in consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of MembersMember, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

1.2. CalOptima's QI Department may deem it appropriate to deploy CalOptima's copying vendor to copy and provide medical records.

2.3. CalOptima's QI Department shall target to complete its review upon the receipt of the case review response, medical records, and/or other supporting documentation, within one hundred twenty (120) calendar days.

C. Evaluation of Findings and Determination of IfAction of Medically Related Issues

4. ~~Upon receipt of satisfactory documentation from~~ the ~~Provider, Practitioner, Health Network, or HDO identified in~~case is determined by the QI Nurse to be QOS, the case shall be closed and a resolution letter will be sent by the PQI ~~case, a QI Nurse~~team.

   a. If the case was referred by an internal CalOptima Department, notification of the QOS determination will be communicated to the referring department for educational purposes.

   b. The CalOptima PQI team shall ~~evaluate~~send a resolution letter to the Member.

   c. If the Member chooses to remain anonymous, the case~~, review,~~ will be flagged as confidential and ~~summarize any~~no resolution letter will be sent to the Member.

   d. If the case was not referred by a Member or a Member's representative, no resolution letter will be sent to the Member.

~~3.~~5. If the case is determined by the QI Nurse to be QOC, findings will be summarized for evaluation by ~~a~~the CalOptima Medical Director.

~~4.~~6. ~~Upon review, the~~ CalOptima Medical Director shall ~~summarize the case findings and determine~~review with QOC case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the QOC case that reflects the severity ~~level of the case, in accordance with CalOptima Policy GG.1612: Outcome Score for Potential Quality Issues.~~of the outcome.

Outcome Score	Description of Outcome Score
0	No quality of care or quality of service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
H1	Potential clinical care issue with or without an adverse outcome which occurs in a hospital.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.
HDS	Healthcare delivery system issue with or without an adverse outcome.

~~5.~~7. CalOptima shall utilize an external review entity if a second opinion is determined to be needed by a Medical Director.

~~6.~~8. If the CalOptima Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

~~7.~~9. If the CalOptima Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Medical Director or be presented to the CalOptima CPRC for recommendation(s).

a. Higher severity cases will be presented to CPRC for discussion and ~~determination~~recommendation of ~~a CAP~~action.

b. Other cases may be presented to CPRC upon Medical Director's discretion.

~~8.~~10. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC ~~shall:~~may recommend further action.

a. ~~Request~~A corrective action from the specific CalOptima department, Health Network, HDO, Practitioner, or Provider;

b. Require the Practitioner, Provider, Health Network, HDO, or CalOptima department to perform additional educational training; or

c. Require other appropriate action(s) as recommended by the CPRC.

~~9.~~11. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, HDO, Practitioner, Provider, or CalOptima ~~department~~Department.

12. Once the review process is completed, a resolution letter will be sent to the Health Network, the Provider and the Member, if the case was member-generated and not a confidential case.

~~D.~~C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC:

   a. Practitioners, Providers, and HDOs whose PQI rate ~~in the last three (3) years is two (2) standard deviations above the mean~~is greater than practitioner, provider or HDO specialty;

   ~~b. Quarterly Health Network reports forwarded to the Health Networks;~~

   ~~c.~~ Open and closed cases;

   ~~d.~~b. ~~Number of referrals from CalOptima departments;~~ and

   ~~e.~~c. Severity levels and categories of issues.

2. The QI Department shall submit all case findings and recommended actions to the CalOptima CPRC.

3. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

4. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the Quality Improvement Committee (QIC) on a quarterly basis.

5. Additionally, the CalOptima CMO, his or her Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIC to the CalOptima Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima QI Plan.

6. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

7. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

8. The QI Department shall submit a quarterly report to the Health Networks, reporting ~~the status of~~ all closed PQIs affiliated with the specific Health Network.

ATTACHMENT(S)

A. Medical Records Request Form
B. Potential QOC Issue Request for Information Template
C. Health Network ~~Notification~~Resolution Letter
D. Member Resolution Letter (Medi-Cal) ~~MM-16-24_11.28.16~~
E. Member Resolution Letter (OneCare)
F. Member Resolution Letter (OneCare Connect)
~~E.~~G. Member Acknowledgement Letter (Medi-Cal) ~~MM-17-12_11.28.16~~
~~F.~~H. Member Acknowledgement Letter (OneCare)
~~G.~~I. Member Acknowledgement Letter(OneCare Connect)
~~H.~~J. Provider Resolution Letter

REFERENCE(S)

A. California Business and ~~Professional~~Professions Code, §§805 and 1000-1
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
D. CalOptima Three-way Agreement with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~E. CalOptima Policy GG.1612: Outcome Score for Potential Quality Issues~~
~~F.~~E. CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners
~~G.~~F. CalOptima Quality Improvement Plan
~~H.~~G. Title 22, California Code of Regulations (C.C.R), ~~§§52280 and~~ §51051
~~I.~~H. Title 28, California Code of Regulations (C.C.R), §1300.~~70~~85.1
~~J.~~I. Title 42, Code of Federal Regulations (C.F.R), §422.152(~~f~~a)(3), (c)(2), and (d)
J. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/23/2015	Department of Health Care Services (DHCS)
03/28/2016	Department of Health Care Services (DHCS)

BOARD ACTION(S)

None to Date

REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement Committee (QIC).
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role. For the purposes of this policy, a designee acting on behalf of the CalOptima Chief Medical Officer (CMO) shall be a CalOptima Medical Director.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to ~~Members~~members assigned to that Health Network.
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Member	An enrollee-beneficiary of a CalOptima program.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a ~~Member's~~member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing ~~Covered Services~~covered services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, ~~health maintenance organization,~~ or other person or institution that furnishes ~~Covered Services~~covered services.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Term	Definition
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima QI Registered Nurse (RN) or a CalOptima QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for ~~Members~~members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima's programs.

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

PURPOSE

This policy defines the process for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Quality Improvement (QI) Department.

POLICY

A. All CalOptima departments, Practitioners, Providers, Health Networks, and Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the CalOptima Quality Improvement (QI) Department for review and investigation.

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request medical records and/or other CalOptima records as well as pertinent documentation from Providers, as needed.

D. CalOptima's Chief Medical Officer (CMO) or Designee shall refer PQI cases to the CalOptima Credentialing and Peer Review Committee (CPRC) for further evaluation and action, pursuant to the CalOptima Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and HDO PQI data every six (6) months to identify emerging patterns. This data shall be reviewed by the CMO or Designee who shall report any issues and/or emerging patterns to the CalOptima CPRC for further evaluation and action, as necessary.

F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima CPRC.

G. The CPRC shall report a summary of trends and activities to the CalOptima Quality Improvement Committee (QIC) and to the Board of Directors' Quality Assurance Committee (QAC).

H. CalOptima shall maintain confidentiality of quality improvement case review information, in accordance this Policy.

PROCEDURE

Back to Agenda Back to Item

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and HDOs may identify and refer a PQI to CalOptima's QI Department.

2. A PQI may be referred from an internal CalOptima department, including but not limited to, Grievance & Appeals Resolution Services (GARS), Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management (UM), Case Management and Compliance.

3. Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

    a. Any entity referring a PQI case, shall identify if the Member chooses to remain anonymous.

4. A QI Nurse shall perform an initial clinical review within three (3) business days and determine:

    a. If the case is a Quality of Care (QOC) or Quality of Service (QOS) based on the initial information received; and

    b. If the Member has any urgent clinical issues, care coordination will be provided by the QI Nurse.

B. Process, Review and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima PQI team and documented in CalOptima's care management system.

    a. The CalOptima PQI team shall send an acknowledgement letter to the Member.

    b. If the Member chooses to remain anonymous, the case will be flagged as confidential and no acknowledgement letter will be sent to the Member.

    c. If the case was not referred by a Member or a Member's representative, no acknowledgement letter will be sent to the Member.

    d. The QI nurse shall request pertinent medical records and a response to the Member's complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or HDO(s) that rendered medical services or were involved in rendering the medical service(s), as needed. A Provider, Practitioner, Health Network, or HDO shall submit such records and response to the CalOptima QI Department within fourteen (14) calendar days after receipt of the request.

        i. If a Provider, Practitioner, Health Network, or HDO fails to respond within the required timeframe:

            a) The CalOptima QI Department shall follow-up with a minimum of three (3) attempts within thirty (30) business days to obtain the requested information.

            b) CalOptima may request a written and signed explanation for any delay in submitting records or responding to a request for a case review. This document shall become a permanent part of the review record.

            c) If there is no reasonable or acceptable explanation provided by the Provider, Practitioner, Health Network, or HDO, or if the delay continues, CalOptima's QI Department, in

consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of Member, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

2. CalOptima's QI Department may deem it appropriate to deploy CalOptima's copying vendor to copy and provide medical records.

3. CalOptima's QI Department shall target to complete its review upon the receipt of the case review response, medical records, and/or other supporting documentation, within one hundred twenty (120) calendar days.

4. If the case is determined by the QI Nurse to be QOS, the case shall be closed, and a resolution letter will be sent by the PQI team.

   a. If the case was referred by an internal CalOptima Department, notification of the QOS determination will be communicated to the referring department for educational purposes.

   b. The CalOptima PQI team shall send a resolution letter to the Member.

   c. If the Member chooses to remain anonymous, the case will be flagged as confidential and no resolution letter will be sent to the Member.

   d. If the case was not referred by a Member or a Member's representative, no resolution letter will be sent to the Member.

5. If the case is determined by the QI Nurse to be QOC, findings will be summarized for evaluation by the CalOptima Medical Director.

6. CalOptima Medical Director shall review with QOC case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the QOC case that reflects the severity of the outcome.

Outcome Score	Description of Outcome Score
0	No quality of care or quality of service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
H1	Potential clinical care issue with or without an adverse outcome which occurs in a hospital.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.

Outcome Score	Description of Outcome Score
HDS	Healthcare delivery system issue with or without an adverse outcome.

7. CalOptima shall utilize an external review entity if a second opinion is determined to be needed by a Medical Director.

8. If the CalOptima Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

9. If the CalOptima Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Medical Director or be presented to the CalOptima CPRC for recommendation(s).

    a. Higher severity cases will be presented to CPRC for discussion and recommendation of action.

    b. Other cases may be presented to CPRC upon Medical Director's discretion.

10. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC may recommend further action.

    a. A corrective action from the specific CalOptima department, Health Network, HDO, Practitioner, or Provider;

    b. Require the Practitioner, Provider, Health Network, HDO, or CalOptima department to perform additional educational training; or

    c. Require other appropriate action(s) as recommended by the CPRC.

11. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, HDO, Practitioner, Provider, or CalOptima Department.

12. Once the review process is completed, a resolution letter will be sent to the Health Network, the Provider and the Member, if the case was member-generated and not a confidential case.

C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC:

    a. Practitioners, Providers, and HDOs whose PQI rate is greater than practitioner, provider or HDO specialty;

    b. Open and closed cases; and

    c. Severity levels and categories of issues.

2. The QI Department shall submit all case findings and recommended actions to the CalOptima CPRC.

3. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

4. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the Quality Improvement Committee (QIC) on a quarterly basis.

5. Additionally, the CalOptima CMO, his or her Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIC to the CalOptima Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima QI Plan.

6. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

7. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

8. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network.

ATTACHMENT(S)

A. Medical Records Request Form
B. Potential QOC Issue Request for Information Template
C. Health Network Resolution Letter
D. Member Resolution Letter (Medi-Cal)
E. Member Resolution Letter (OneCare)
F. Member Resolution Letter (OneCare Connect)
G. Member Acknowledgement Letter (Medi-Cal)
H. Member Acknowledgement Letter (OneCare)
I. Member Acknowledgement Letter(OneCare Connect)
J. Provider Resolution Letter

REFERENCE(S)

A. California Business and Professions Code, §§805 and 1000-1
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
D. CalOptima Three-way Agreement with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Policy GG.1615A: Corrective Action Plan for Practitioners
F. CalOptima Quality Improvement Plan
G. Title 22, California Code of Regulations (C.C.R), §51051
H. Title 28, California Code of Regulations (C.C.R), §1300.85.1
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J. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/23/2015	Department of Health Care Services (DHCS)
03/28/2016	Department of Health Care Services (DHCS)

BOARD ACTION(S)

None to Date

REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

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Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes covered services.
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Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima's programs.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:** (Intake Staff), QI Program Assistant
Fax:	**Fax:**
Phone:	**Phone:** ~~657-900-1122~~(Phone)

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Member Name:	
DOB:	
CIN:	
Date(s) of Service:	
Case #:	

Dear Medical Records/Health Information Management~~,~~

We are in the process of reviewing professional services rendered for the CalOptima member indicated above. Please submit ~~to my personal attention~~ a copy of the following reports **to my attention**:

❒ Discharge Summary
❒ Consultation Reports
❒ Medication Records
❒ Laboratory Reports
❒ Microbiology Reports
❒ Admission History & Physical
❒ Operative and Procedure Reports
❒ X-~~R~~ray/Diagnostic/Radiology Imaging Reports
❒ Emergency Room Medical Records
❒ (~~UserContent.~~ Other Reports)
~~❒ (UserContent. Other Reports)~~

The authorization to release such information is granted by Title 22, California Code of Regulations, Section 51009. All records shall be held confidential in accordance with California law. Please address your **"CONFIDENTIAL"** response via or by mail to:

CalOptima
Quality Improvement Department
~~Attention: NURSE'S NAME~~
505 City Parkway West~~,~~
Orange, CA 92868

~~Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

I appreciate y~~Y~~our prompt attention to this matter by (Date) ~~will be appreciated~~. ~~-~~ Should you have any questions regarding this request, please ~~feel free to~~ contact me at ~~-~~**NURSE'S PHONE**.

Sincerely,

NURSE'S NAME
QI Nurse Specialist
Quality Improvement

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

CONFIDENTIALITY WARNING: Information contained in this FAX is CONFIDENTIAL. This is intended for the use of the individual or entity named above. If the reader of this FAX message is not the intended recipient, the employee, or agent responsible to deliver it to the intended recipient, you are hereby on notice that you are in possession of confidential information. Any unauthorized distribution, copying, or dissemination of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify CalOptima by telephone toll-free at **888-587-8088** and/or return this fax message to the following fax number **657-900-1615**.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:** (Intake Staff), QI Program Assistant
Fax:	**Fax:**
Phone:	**Phone:** (Phone)

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Member Name:	
DOB:	
CIN:	
Date(s) of Service:	
Case #:	

Dear Medical Records/Health Information Management:

We are in the process of reviewing professional services rendered for the CalOptima member indicated above. Please submit a copy of the following reports **to my attention**:

❒ Discharge Summary
❒ Consultation Reports
❒ Medication Records
❒ Laboratory Reports
❒ Microbiology Reports
❒ Admission History & Physical
❒ Operative and Procedure Reports
❒ X-ray/Diagnostic/Radiology Imaging Reports
❒ Emergency Room Medical Records
❒ (Other Reports)

The authorization to release such information is granted by Title 22, California Code of Regulations, Section 51009. All records shall be held confidential in accordance with California law. Please address your **"CONFIDENTIAL"** response via or by mail to:

CalOptima
Quality Improvement Department
505 City Parkway West
Orange, CA 92868

I appreciate your prompt attention to this matter by (Date). Should you have any questions regarding this request, please contact me at **NURSE'S PHONE.**

Sincerely,

NURSE'S NAME
QI Nurse Specialist
Quality Improvement

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

CONFIDENTIALITY WARNING: Information contained in this FAX is CONFIDENTIAL. This is intended for the use of the individual or entity named above. If the reader of this FAX message is not the intended recipient, the employee, or agent responsible to deliver it to the intended recipient, you are hereby on notice that you are in possession of confidential information. Any unauthorized distribution, copying, or dissemination of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify CalOptima by telephone toll-free at **888-587-8088** and/or return this fax message to the following fax number **657-900-1615**.

Medi-Cal CalOptima Better. Together.

CalOptima Better. Together.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:**
Fax:	**Fax:**
Phone:	**Phone:**

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Potential Quality of Care Issue / Request for Information

1. Please submit the information requested by **DUE DATE**. If the deadline is missed, CalOptima may have to resolve the complaint without the benefit of your ~~recommendation~~information and/or response.
2. **Type of Complaint**: ❒ Quality of Care issue filed by the member
   ❒ Quality of Care issue filed by the family member
   ❒ Clinical issue filed by CalOptima staff
3. **Member Name:** **Case Number:**
   DOB: **CIN:**

   Provider/Facility Name:
   DOS:
4. **Medical Records Requested:**
   ❒ Provider Notes ❒ Problem List
   ❒ Medication List ❒ Labs
   ❒ OTHER ❒ Diagnostic Reports

Dear Provider:

In order to ensure a balanced review, your input is vital. At this time, ~~the~~ CalOptima's Quality Improvement ~~D~~department is requesting a **written response** from your office regarding the member's concerns. ~~Note, that these concerns are not reported to the California Medical Board.~~

COMPLAINT

The nurse assigned to this case is **NURSE'S NAME**. For **clinical questions** regarding the response or records, please call the nurse at **NURSE'S PHONE**. For all other inquiries, please ~~refer to the~~ contact the sender at the ~~number~~ phone number listed at the top of the fax.

~~.Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

~~Thank you for your prompt attention to this request.~~

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

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FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:**
Fax:	**Fax:**
Phone:	**Phone:**

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Potential Quality of Care Issue / Request for Information

1. Please submit the information requested by **DUE DATE**. If the deadline is missed, CalOptima may have to resolve the complaint without the benefit of your information and/or response.

2. **Type of Complaint**:
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3. **Member Name:** **Case Number:**
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   Provider/Facility Name:
   DOS:

4. **Medical Records Requested:**
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   ❒ OTHER ❒ Diagnostic Reports

Dear Provider:

In order to ensure a balanced review, your input is vital. At this time, CalOptima's Quality Improvement department is requesting a **written response** from your office regarding the member's concerns.
COMPLAINT

The nurse assigned to this case is **NURSE'S NAME**. For **clinical questions** regarding the response or records, please call the nurse at **NURSE'S PHONE**. For all other inquiries, please contact the sender at the phone number listed at the top of the fax.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

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Quality Improvement Department
Potential Quality of Care Issue

DATE

Peer Review Conclusion

Dear HEALTH NETWORK:,

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. According to the documentation received, the committee reviewed and closed this case on DATE and ~~leveled it~~assigned an outcome score of ~~at~~ SEVERITY CODE – SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Date Complaint Ssent to HN:
Case Number:
Name of Provider:
Summary of Complaint: COMPLAINT CATEGORY-COMPLAINT SUBCATEGORY
Final Determination: RESOLUTION SUBCATEGORY
Reviewed by: MEDICAL DIRECTOR
Confidential Case*: ❒ Yes | ❒ No

Please ~~feel free to~~ contact me if you have any further questions at ~~(657) 900-1122~~**(Phone Number)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means

that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

~~S.Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

Sincerely,

(Name)~~Laura Guest, RN, ANP Supervisor~~(TITLE), Quality Improvement
~~(657) 900-1122~~(Phone #)
~~lguest@caloptima.org~~(E-mail)

*Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

Quality Improvement Department
Potential Quality of Care Issue

DATE

Peer Review Conclusion

Dear HEALTH NETWORK:

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. According to the documentation received, the committee reviewed and closed this case on DATE and assigned an outcome score of SEVERITY CODE — SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Date Complaint Sent to HN:
Case Number:
Name of Provider:
Summary of Complaint: COMPLAINT CATEGORY-COMPLAINT SUBCATEGORY
Final Determination: RESOLUTION SUBCATEGORY
Reviewed by: MEDICAL DIRECTOR
Confidential Case*: ❒ Yes | ❒ No

Please contact me if you have any further questions at **(Phone Number)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

Sincerely,

(Name)
(TITLE), Quality Improvement

*Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

DATE

MEMBER NAME
ADDRESS
CITY, STATE ZIP

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear Mr./Ms. MEMBER NAME,

On DATE OF INCIDENT, CalOptima received your complaint about the care or services you received. CalOptima and its contracted health network and providers ~~medical groups~~ make every effort to provide the highest quality health care services to our members. CalOptima regrets not meeting your needs and apologizes for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,
Quality Improvement

(714) 246-8400

MM_16_24

NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact CalOptima between 8:00 a.m. – 5:30 p.m. by calling 1-714-246-8500. Or, if you cannot hear or speak well, please call TYY/TDD 1-800-735-2929.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8:00 a.m. and 5:30 p.m. by calling 1-888-587-8088. Or, if you cannot hear or speak well, please call 1-800-735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868
- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.

- Electronically: Visit CalOptima's website at www.caloptima.org.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-587-8088 (TTY: 1-800-735-2929).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-587-8088 (TTY: 1-800-735-2929).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-888-587-8088 (TTY: 1-800-735-2929).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung ikaw ay nagsasalita sa wikang Tagalog, may mga serbisyo sa pananalita na makakatulong sa iyo na maari mong gamitin nang walang bayad. Tumawag sa 1-888-587-8088 (TTY: 1-800-735-2929).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-587-8088 (TTY: 1-800-735-2929)번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您说繁體中文，您可以免費獲得語言援助服務。請致電 1-888-587-8088（TTY：1-800-735-2929）。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-587-8088 (телетайп: 1-800-735-2929).

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-888-587-8088** (TTY: **1-800-735-2929**) تماس بگیرید.

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-587-8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEBTOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, pab dawb rau koj. Hu rau 1-888-587-8088 (TTY: 1-800-735-2929).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-888-587-8088.**

हिंदी (Hindi)

ध्यान दें : यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-587-8088 (TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)

ข้อควรคำนึง: ถ้าหากคุณพูดภาษาไทย, คุณสามารถใช้บริการความช่วยเหลือทางภาษา, โดยไม่เสียค่าใช้จ่ายใด ๆ ได้โดย, โทร 1-888-587-8088 (TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)
ចំណុចសំខាន់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយផ្នែកភាសាគឺមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໄດ້. ໂທຫາ 1-888-587-8088 (TTY: 1-800-735-2929).

MCAL MM-17-77_DHCS Approved 10.04.17_Updated Language Assistance Tagline

DATE

MEMBER NAME
ADDRESS
CITY, STATE ZIP

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear Mr./Ms. MEMBER NAME,

On DATE OF INCIDENT, CalOptima received your complaint about the care or services you received. CalOptima and its contracted health network and providers make every effort to provide the highest quality health care services to our members. CalOptima regrets not meeting your needs and apologizes for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

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We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,
Quality Improvement
(714) 246-8400

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
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Back to Agenda Back to Item

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  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  - ✓ Information written in other languages

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HOW TO FILE A GRIEVANCE

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- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
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Back to Agenda Back to Item

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Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-888-587-8088 (TTY: 1-800-735-2929).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung ikaw ay nagsasalita sa wikang Tagalog, may mga serbisyo sa pananalita na makakatulong sa iyo na maari mong gamitin nang walang bayad. Tumawag sa 1-888-587-8088 (TTY: 1-800-735-2929).

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Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-587-8088 (телетайп: 1-800-735-2929).

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-888-587-8088** (TTY: **1-800-735-2929**) تماس بگیرید.

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

日本語 (Japanese)
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1-888-587-8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEBTOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, pab dawb rau koj. Hu rau 1-888-587-8088 (TTY: 1-800-735-2929).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-888-587-8088.**

हिंदी (Hindi)

ध्यान दें : यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-587-8088 (TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)

ข้อควรคำนึง: ถ้าหากคุณพูดภาษาไทย, คุณสามารถใช้บริการความช่วยเหลือทางภาษา, โดยไม่เสียค่าใช้จ่ายใด ๆ ได้โดย, โทร 1-888-587-8088 (TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)
ចំណុចសំខាន់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយផ្នែកភាសាគឺមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໄດ້. ໂທຫາ 1-888-587-8088 (TTY: 1-800-735-2929).

MCAL MM-17-77_DHCS Approved 10.04.17_Updated Language Assistance Tagline

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear ~~<Member Name>~~Mr./Ms. ~~:~~,

On (Insert Date)~~<Date>~~, OneCare (HMO SNP) received your complaint about the care or services you received. OneCare and its contracted health networks and providers make every effort to provide the highest quality health care services to our members. OneCare regrets not meeting your needs and ~~apologizes~~ is sorry for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,

Quality Improvement
1-~~(~~714~~)~~ 246-8400

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. ~~TDD/~~TTY users can call **1-800-735-2929**.

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

H5433_GA17_1_NM

LANGUAGE ASSISTANCE

English ATTENTION: If you speak another language, language assistance services, free of charge, are available to you.– Call ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.– Llame al ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.– Gọi số ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Tagalog (Tagalog – Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.– Tumawag sa ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.– ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**)번으로 전화해 주십시오.

繁體中文 (Chinese) 注意： 如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 ~~1-877-412-2734~~ **1-877-412-2734** （TTY：~~1-800-735-2929~~**1-800-735-2929**）。

Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք ~~1-877-412-2734~~ **1-877-412-2734** (TTY (հեռատիպ)՝ ~~1-800-735-2929~~**1-800-735-2929**):

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Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.– Hu rau ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-412-2734
(رقم هاتف الصم والبكم: 1-800-735-2929).

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ภาษาไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

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ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.– ໂທຣ ~~1-877-412-2734~~ **1-877-412-2734** (TTY: ~~1-800-735-2929~~**1-800-735-2929**).

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

On (Insert Date), OneCare (HMO SNP) received your complaint about the care or services you received. OneCare and its contracted health networks and providers make every effort to provide the highest quality health care services to our members. OneCare regrets not meeting your needs and is sorry for any problems this may have caused.

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Quality Improvement
1-714-246-8400

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H5433_GA17_1_NM

LANGUAGE ASSISTANCE

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ខ្មែរ (Cambodian) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-877-412-2734** (TTY: **1-800-735-2929**)។

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-412-2734** (TTY: **1-800-735-2929**).

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear ~~Mr./Mrs. <Member Name>:~~,

On (Insert Date)~~<Date>~~, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) received your complaint about the care or services you ~~received~~were given. OneCare Connect and its contracted health networks and providers make every effort to provide the highest quality health care services to our members. OneCare Connect regrets not meeting your needs and ~~apologizes~~ is sorry for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

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We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,

Quality Improvement
~~(~~1-714~~)~~ 246-8400

H8016_GA17_1C Approved (6/20/2017)

Notice of Nondiscrimination

OneCare Connect Cal MediConnect Plan (Medicare- Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare Connect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare Connect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week. ~~TDD/~~TTY users can call **1-800-735-2929**. If you believe that OneCare Connect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance & Appeals
505 City Parkway West, Orange, CA 92868
Telephone number: 1-714-246-8554
TTY number: **1-800-735-2929**
Fax: 1-714-246-8562
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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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LANGUAGE ASSISTANCE

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-705-8823 (TTY: 1-800-735-2929) تماس بگیرید.

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Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-705-8823
(رقم هاتف الصم والبكم: 1-800-735-2929).

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

ภาษาไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-855-705-8823** (TTY: **1-800-735-2929**).

Notification to Member
Resolution of Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

On (Insert Date), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) received your complaint about the care or services you were given. OneCare Connect and its contracted health networks and providers make every effort to provide the highest quality health care services to our members. OneCare Connect regrets not meeting your needs and is sorry for any problems this may have caused.

Our Quality Improvement department reviewed your concerns and took all steps needed to fix the issue(s). We want you to know that we have a plan in place to meet all standards if they have not already been met. We will keep track of these issues to improve our program and prevent future problems.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

We thank you for your input because it helps us better assist you and all our members with their health care needs.

Sincerely,

Quality Improvement
1-714-246-8400

H8016_GA17_1C Approved (6/20/2017)

Notice of Nondiscrimination

OneCare Connect Cal MediConnect Plan (Medicare- Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare Connect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare Connect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week. TTY users can call **1-800-735-2929**. If you believe that OneCare Connect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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505 City Parkway West, Orange, CA 92868
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200 Independence Avenue, SW
Room 509F, HHH Building
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LANGUAGE ASSISTANCE

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Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

Thank you for letting us know about your complaint telling us that you were not satisfied with part of CalOptima's program on [date]. CalOptima takes your complaint seriously, and we will launch an investigation right away. We apologize for any problem this may have caused you.

CalOptima and its contracted health networks and providers work hard to provide the highest quality health care services to our members.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

If you or your family would like this letter translated into a different language, please call the CalOptima Customer Service department toll-free at **1-888-587-8088**. TTY users can call toll free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Quality Improvement

Enclosures:
Language Assistance Taglines
Nondiscrimination Notice

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500

Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

Thank you for letting us know about your complaint telling us that you were not satisfied with part of the OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Plan on <date>. OneCare Connect takes your complaint seriously, and we will launch an investigation right away. We are sorry for any problem this may have caused you.

OneCare Connect and its contracted health networks and providers work hard to provide the highest quality health care services to our members.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

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Sincerely,

Quality Improvement

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Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم **1-855-705-8823** (TTY: **1-800-735-2929**).

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 855-705-8823 | Main: 714-246-8400 | Fax: 714-246-8711 | TDD/TTY: 800-735-2929

H8016_20MM073 Accepted 12/28/2019

Back to Agenda Back to Item

Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear : ~~Mr./Mrs.~~

Thank you for letting us know about your complaint ~~in which you expressed~~ ~~shared~~telling us that you were not satisfied ~~dissatisfaction~~ with part of the OneCare (HMO SNP) program on (Insert Date). ~~-~~OneCare takes your complaint seriously, and we will ~~immediately~~ launch an investigation ~~at once~~right away. ~~-~~We ~~apologize~~ are sorry for any problem this may have caused you.

OneCare and its contracted health networks and providers work hard to provide the highest quality health care services to our members.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code~~-~~, Section 1370; as well as the Business and Professions Code, section 805.~~-~~This means that you will not receive the results of our research into your complaint. ~~-~~Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

If you or your family ~~wants~~ would like this letter translated into a different language, please c~~C~~all OneCare Customer Service toll-free 7 days a week, 24 hours a day, at~~1-877-412-2734~~ 1-877-412-2734. ~~TTY/~~T~~DD~~TY users can call toll-free at ~~1-800-735-2929~~1-800-735-2929. ~~-~~We have staff who speak your language.

Sincerely,

Quality Improvement

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age,

disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. ~~TDD/~~TTY users can call **1-800-735-2929**.

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Notification to Member
Acknowledging Potential Quality of Care

Re: Member Name:
Member ID #:
DOB:
Affiliated Health Network/PMG:

Dear :

Thank you for letting us know about your complaint telling us that you were not satisfied with part of the OneCare (HMO SNP) program on (Insert Date). OneCare takes your complaint seriously, and we will launch an investigation right away. We are sorry for any problem this may have caused you.

OneCare and its contracted health networks and providers work hard to provide the highest quality health care services to our members.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

If you or your family would like this letter translated into a different language, please call OneCare Customer Service toll-free 7 days a week, 24 hours a day, at **1-877-412-2734**. TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Quality Improvement

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. TTY users can call **1-800-735-2929**.

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Quality Improvement Department
Potential Quality of Care Issue

DATE

PROVIDER
ADDRESS
CITY, STATE ZIP CODE

Peer Review Conclusion

Dear PROVIDER~~,~~:

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. ~~–~~According to the documentation received, the committee reviewed and closed this case on DATE and ~~leveled it at~~assigned an outcome score of SEVERITY CODE and SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Case Number:
Date of Incident:
Name of Health Network:
Summary of Complaint: COMPLAINT CATEGORY ~~–~~ COMPLAINT SUBCATEGORY)
Final Action:
Confidential Case*: ☐ **Yes** | ☐ **No**

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.
~~,S.Please note that per California law, known as Evidence Code Section 1157, the Health and Safety Act, Section 1370; as well as the California Business and~~

~~Professional Code, Section 805, CalOptima is prohibited from sharing the results of the investigation. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action as necessary, to make sure members receive quality health care services.~~

Please contact QI ~~Supervisor~~(Title) ~~Laura Guest, RN, ANP~~(Nname), ~~QI Supervisor,~~ if you have any questions at ~~(657) 900-1122~~(Phone). Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Sincerely,

~~Miles Masatsugu, M.D.~~(Name)
Medical Director
qualityofcare@caloptima.org

* Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

Quality Improvement Department
Potential Quality of Care Issue

DATE

PROVIDER
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Policy:	GG.1615Δ
Title:	**Corrective Action Plan for Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	04/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

~~To define~~This policy defines the appropriate corrective action process that CalOptima shall use for Practitioners, including routine monitoring, investigation, and ~~education,~~ corrective action~~, summary suspension, automatic suspension,~~ related to his or ~~limitation or termination~~her clinical practice.

II. POLICY

~~A. CalOptima has the responsibility for conducting any investigation, and initiating corrective action against a Practitioner to ensure the safety of CalOptima Members.~~

~~B. CalOptima, a Health Network (HN), or a Physician Medical Group (PMG) shall suspend, restrict, or terminate a Practitioner's participation, in accordance with the terms and conditions of this policy.~~

~~C. CalOptima, HN or PMG shall notify a Practitioner, in writing, of a decision, which shall include the reasons, standards, and data used to make such decision, to suspend, restrict, or terminate the Practitioner.~~

~~D. CalOptima, the HN, or PMG shall notify a Practitioner, in writing, at least sixty (60) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.~~

~~E. CalOptima shall notify the National Practitioner Data Bank (NPDB), the Medical Board of California (MBOC), the Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), and any other applicable regulatory body, of corrective action when required to do so by law.~~

~~A. Routine Monitoring and Education~~

~~1. Responsibility~~

~~F.~~A. The Quality Improvement Committee (QIC) oversees CalOptima's quality improvement activities. CalOptima's Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are responsible for the ~~quality~~Quality of ~~care~~Care and service provided by CalOptima.

Back to Agenda Back to Item

~~G.~~B. ~~It shall be the responsibility of the~~The CalOptima's CMO or his or her ~~designee~~physician Designee working through, as appropriate, such standing or ad hoc peer review committee as CalOptima may from time to time establish, ~~to~~shall design and implement an effective quality program for the following purposes:

1. To monitor and assess the quality of professional practice of all Practitioners; and

2. To promote high quality of practice by providing education and counseling~~:~~, issuing letters of admonition, warning or censure, as necessary; and requiring routine monitoring when deemed appropriate by CalOptima or ~~its peer review committees.~~the CalOptima Credentialing and Peer Review Committee (CPRC).

~~3.Require routine monitoring when deemed appropriate by CalOptima or its peer review body.~~

~~2. Procedure~~

~~a. Review and Studies~~

C. ~~CalOptima and its QIC,~~CalOptima may conduct an investigation and initiate corrective action against a Practitioner in any Health Network, including to investigate Member complaints and ensure the safety of CalOptima Members.

D. CalOptima shall take corrective action, for a non-medical and ~~Credentialing~~medical disciplinary cause or reason, in accordance with the terms and conditions of this Policy.

E. Corrective actions may be imposed based on administrative or clinical findings. Certain investigations and corrective actions (*e.g.*, restriction of members or services) taken on the basis of a medical disciplinary cause or reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB).

F. CalOptima shall implement any suspension or restriction imposed on a Practitioner for a medical disciplinary cause or reason in accordance with CalOptima Policy GG.1658

G. CalOptima shall notify a Practitioner, in writing, in accordance with that Practitioner's contract, but in no case less than sixty (60) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.

H. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners with a corrective action process when the Health Network takes or proposes action including routine monitoring, corrective action, or investigation related to a Practitioner's clinical practice.

III. PROCEDURE

A. Routine Monitoring

1. All Practitioners, regardless of status, shall be subject to ~~Peer Review Committees (CCPRC)~~routine monitoring.

~~1.~~2. The Quality Improvement (QI) Department shall conduct regular patient ~~care~~ reviews and studies of practice consistent with CalOptima general quality assessment and improvement

activities and shall investigate Potential Quality Issues and complaints and ~~unusual practice-related~~Quality of Care incidents~~. The QIC~~ in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process, and shall ~~meet at a minimum on quarterly basis~~report to ~~review all cases presented and reviewed at~~ the ~~CCPRC which meets a minimum of four (4) times a year~~CPRC the results of investigations deemed a Quality of Care issue.

3. The QI Department shall routinely monitor, trend, and analyze Practitioner Potential Quality Issues (PQI) cases and Grievances.

~~b. If Informal Counseling and Education~~

any issues or trends emerge with any Practitioner during the monitoring process, and

~~2.~~4. ~~In order~~ to assist Practitioners to conform their conduct or ~~practitioner~~Practitioner practice to the standards of CalOptima, the CMO or his or her ~~designee~~physician Designee may issue informal comments or suggestions, either orally or in writing~~.~~ or take corrective action as outlined in Section III.C. of this Policy.

~~3.~~5. ~~Such~~Informal comments or suggestions shall be confidential~~,~~ and may be issued by the CMO or his or her ~~designee~~physician Designee with or without prior discussion with the recipient, and with or without consultation with any CalOptima committee.

~~4.~~6. Such comments or suggestions shall not constitute a restriction of practice prerogatives, and shall not be considered to be ~~"~~a "corrective action" as that term is used in Section III.~~B of this policy, and shall not give rise to hearing rights under the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners~~C.

~~c. Notification of Concerns: Routine Monitoring~~

~~a. Following discussion of identified concerns with any Practitioner, the QIC and CCPRC, as applicable, may recommend that the CMO or his or her designee issue a letter of admonition, warning or censure, or to require such Practitioner to be subject to routine monitoring for such time as may appear reasonable.~~

~~b. All Practitioners, regardless of status, shall be subject to potential routine monitoring. The discussion of such actions with individual Practitioners shall be informal. Such action shall not constitute a restriction of practice prerogatives and shall not be considered to be "corrective action," as that term is used in Section III.B of this policy, and shall not give rise to hearing rights under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.~~

~~5.~~7. The term "routine monitoring," as used in this section, shall mean review of a Practitioner's practice and may include activities for which the Practitioner's only obligation is to provide reasonable advance notice to any CalOptima committee or representative of certain patient care procedures or other patient care activity.

B. Corrective Action for Medical Disciplinary or Non-Medical Disciplinary Cause or Reason

1. Criteria for Initiation

a. Any person may provide information to the CMO, the QIC or ~~CCPRC~~CPRC about the conduct, performance, or competence of any CalOptima ~~Direct~~ Practitioner.

b. A request for an investigation or action against a CalOptima Practitioner may be initiated by the CalOptima CMO, the CEO, the QIC or ~~CCPRC~~CPRC, or the Quality Improvement Department when reliable information indicates that the Practitioner ~~may have~~has exhibited acts, demeanor, or conduct reasonably likely to be:

i. Detrimental to patient safety or to the delivery of quality patient care;

ii. Unethical;

iii. Contrary to CalOptima policies, rules, and regulations;

iv. Contrary to his/her CalOptima agreement (if applicable), or,

v. Below applicable CalOptima Practitioner standards.

2. Initiation

a. A request for an investigation must be submitted to the CalOptima CPRC by a person or committee ~~listed above, and~~, such as CMO, the CEO, or the QIC, and must be supported by reference to specific activities or conduct alleged to be detrimental to patient safety or to the delivery of quality patient care, unethical, contrary to CalOptima policies or the CalOptima ~~agreement~~contract (if applicable), or below CalOptima Practitioner standards. If the CPRC initiates the investigation, it shall record the reasons for the investigation in committee meeting minutes.

3. Investigation

a. If the CalOptima CPRC concludes that an investigation is warranted ~~with regard to a Practitioner~~, it shall direct an investigation to be undertaken.

i. The CPRC may conduct the investigation ~~itself,~~ or may assign ~~the task~~non-medical/administrative investigations to another ~~individual~~CalOptima Committee or ~~body.~~ Department.

ii. If the investigation is delegated to a body or individual other than the CPRC, such body or individual shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the CPRC as soon as possible. The report may include recommendations for appropriate corrective action.

iii. If, during the investigation, a reportable corrective action for a Medical Disciplinary Cause or Reason is contemplated, the Practitioner shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual or body deems appropriate.

iv. The individual or body investigating the matter may, but is not obligated to, interview the persons involved. Such interviews shall not constitute a "hearing," ~~as that~~in the manner the term is used in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioner, nor shall any of the procedural rules for hearings apply.

v. Despite the status of any investigation, the CPRC ~~at all times~~always retains authority and discretion to take whatever action may be warranted by the circumstances,

including summary termination of participation, termination of the investigative process, or other action.

vi. Investigations shall be completed within sixty (60) calendar days unless otherwise directed by the CPRC.

b. In the event of a formal investigation during the credentialing (or recredentialing) process and the provider withdraws his or her application, CalOptima shall determine if an 805 report and/or report to the NPDB is required in accordance with CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

4. Corrective Action

a. Corrective action can be taken as a result of issues found through routine monitoring and subsequent PQI investigations in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review process, or as a result of issues found during formal investigations.

b. The corrective action ~~As soon as practical after~~may be for a non-medical/administrative reason or a medical, disciplinary cause or reason, and if for a medical disciplinary cause or reason may result in a reportable action.

~~a.~~c. At the conclusion of the investigation, the CPRC shall determine whether to recommend any corrective action, and if so, whether the corrective action recommended is for a ~~"~~non-medical or medical disciplinary cause or reason.~~" Actions which the CPRC may recommend shall include, without limitation, the following:~~, and will determine if action is reportable pursuant to CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

~~i. Determining that no corrective action should be taken;~~

d. Corrective action for a Non-Medical Disciplinary Cause or Reason

i. If a corrective action is recommended for a "non-medical disciplinary cause or reason" such as customer service-related issues or delays in responding to medical records requests, which the CPRC may take, shall include, without limitation, the following:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant;

b) Sending the Practitioner a community best practice letter;

c) Recommending Practitioner education;

d) Recommending office staff training;

e) Requesting a written Corrective Action Plan (CAP), with appropriate time frames for correction, from the Practitioner demonstrating how the issue will be prevented in the future;

f) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action; or

g) Taking other actions deemed appropriate under the circumstances, including, but not limited to, closing physician panels or freezing specialist referrals.

ii. A corrective action for a "non-medical disciplinary cause or reason" shall not constitute a restriction of practice prerogatives, shall not be considered to be a reportable corrective action for a "medical disciplinary cause or reason" as that term is used in Section III.C.4.e. of this Policy, and shall not give rise to hearing rights as outlined in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

iii. If no improvement is found after the "non-medical disciplinary" corrective action is taken within the specified time frame, and the issue addressed in the action is a contractual requirement, the CPRC may escalate the case to CalOptima's Office of Compliance for further action.

e. Corrective action for a "Medical Disciplinary Cause or Reason"

i. If a corrective action is recommended for a "medical disciplinary cause or reason," CPRC may recommend one or more of the following actions:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

b) Sending the Practitioner a community best practice letter.

c) Recommending Practitioner education.

d) Recommending a written Corrective Action Plan from the Practitioner clearly demonstrating how the issue will be prevented in the future.

~~a)~~e) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her ~~designee~~physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action.

f) Recommending ~~the imposition of terms of probation~~ mandatory participation in: UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or ~~special limitation upon~~ a Physician Enhancement Program (PEP).

~~b)a)~~Imposing, or the Practitioner's ~~participation, including, without limitation, requirements for mandatory consultation or monitoring~~voluntarily acceptance of, a~~;~~

g) ~~Recommending reduction, modification, limitation,~~ suspension~~,~~ of or ~~termination of~~ restrictions on a Practitioner's provision of services to CalOptima Members.

h) Terminating the practitioner's participation~~;~~ in CalOptima's network.

ii. Actions taken for a "Medical Disciplinary Cause or Reason" may require reporting to the California Medical Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Policy GG.1657Δ: Medical Board of California and the National

Practitioner Data Bank (NPDB) Reporting. Reporting under that policy may also be required upon resignation or a leave of absence by a Practitioner from participation in CalOptima programs after notice of an investigation initiated for a "Medical or Disciplinary Cause or Reason."

~~ii. Taking other actions deemed appropriate under the circumstances.~~

iii. For an action that must be reportable under Section 805/809.1 hearing eligible, as described in CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network, include medical disciplinary cause or reasons such as:

a) Incompetence;

b) Gross deviation from the standard of care;

c) Self-prescribing or self-administering controlled substances;

d) Abusing drugs or alcohol;

e) Repeated acts of excessive prescribing or providing controlled substances, and

f) Sexual misconduct with a patient.

iv. If the investigation concludes there is nothing of merit, no corrective action will be taken.

C. Subsequent Actions

~~a.~~ If the CPRC recommends any reportable corrective action which would entitle a Practitioner to request a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, the CPRC shall give the Practitioner written notice of its recommendation, as provided in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners~~.~~ prior to imposing such action. A copy of that notice shall be sent to the QIC for ~~information~~informational purposes only. The CPRC shall also ~~report~~ provide notice to CalOptima's Office of Compliance and to Legal Affairs.

1. ~~If the CPRC decides to impose a summary suspension, termination, or summary restriction of the Practitioner's participation, the CPRC shall provide the Practitioner with written notice at least sixty (60) calendar days prior to imposing such action.~~ The written notice shall include:

a. The reasons for the action;

b. The standards and profiling data used to evaluate the Practitioner; and

c. Information regarding the Practitioner's ~~Appeal~~appeal rights.

D. CPRC

1. Any CPRC action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIC.

2. If the CPRC does not recommend any corrective action which would entitle the CalOptima ~~Direct~~ Practitioner to a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing for Practitioners, the CPRC shall either file its report with a recommendation of no further action or take the action that is not reportable.

3. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These medical disciplinary causes or reasons covered by Section 805.01 are:

   a. Incompetence;

   b. Gross deviation from the standard of care;

   c. Self-prescribing or self-administering controlled substances;

   d. Abusing drugs or alcohol;

   e. Repeated acts of excessive prescribing or providing of controlled substances; and
   f. Sexual misconduct with a patient.

E. Action Initiation by QIC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIC may direct the CPRC to initiate investigation or disciplinary action.

2. If the CPRC fails to take action in response to that direction from the QIC, the QIC may initiate corrective action.

~~F. Summary Suspension Or Restriction~~

~~1. Criteria for Summary Suspension or Restriction~~

~~a. Whenever the failure to immediately suspend or restrict a Practitioner's practice in CalOptima may result in imminent danger to the health of any individual, the CalOptima CMO or his or her designee, the CEO, or the CPRC, or the QIC, shall have the authority to summarily suspend or restrict a contracted Practitioner's practice prerogatives.~~

~~G. Authority to Impose Summary Suspension or Restriction~~

~~a. If the CalOptima CMO or his or her designee, the CEO, the CPRC, or the QIC is not available to summarily restrict or suspend the Practitioner's participation in CalOptima, a designated member of the CPRC may immediately suspend a Practitioner's participation with CalOptima if there is imminent danger to the health of any patient, prospective patient, or to any other individual.~~

~~b. Any restriction or suspension by any of those individuals in Section III.J of this policy is subject to ratification by the CPRC. When such ratification is required, the members shall be notified of the summary suspension immediately, both orally and in writing.~~

c. If the CPRC does not ratify such a summary suspension within two (2) calendar days, excluding weekends and holidays, the summary restriction or suspension shall terminate automatically.

H. Initiation of Summary Action

a. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall immediately give oral and written notice, via certified mail, to the Practitioner and also shall notify in writing the CMO, CEO, CPRC, and QIC within five (5) calendar days after imposition of such suspension.

b. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

c. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's Members shall be promptly assigned to another Practitioner considering, where feasible, the wishes of a Member in the choice of a substitute Practitioner.

d. The written notice shall inform the Practitioner of his or her right to request that the CPRC review the suspension under Section III.B of this policy, and that the Practitioner may attend the review.

e. The CPRC may recommend further corrective action as appropriate based on information disclosed or otherwise made available to it or it may direct that an investigation be undertaken in accordance with Section III.B of this policy.

b.a. The notice of the summary suspension or restriction given to the CPRC shall constitute a request for corrective action, and the procedures set forth in Section III.B of this policy shall be followed.

f. The corrective action investigation shall be completed promptly so any hearing on the summary suspension or restriction and corrective action can be commenced within the sixty (60) day limits after a hearing on a summary suspension is requested. However, because of the summary nature of the action, reasonable efforts should be made to complete the investigation and to schedule the hearing as promptly as is feasible under the circumstances and as permitted by relevant law.

I. CalOptima CPRC Action

a. Within two (2) calendar days, excluding weekends and holidays, after such summary restriction or suspension has been imposed, a meeting of the CPRC shall be convened to review and consider the action.

b. Upon request of the Practitioner or the CPRC, the Practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the CPRC may impose. In no event shall any such meeting of the CPRC, with or without the Practitioner, constitute a "hearing" nor shall any of the procedural rules for hearings apply, nor shall either party be represented by counsel.

c. The CPRC may modify, continue, or terminate the summary restriction or suspension.

d. The CPRC shall provide the Practitioner with notice of its decision.

~~J. Procedural Rights~~

~~1. The Practitioner shall be entitled to hearings and appeals procedures pursuant to the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if the summary restriction or suspension is not promptly terminated by CPRC.~~

~~2. Any suspension that exceeds fourteen (14) days shall be reported to the Medical Board of California pursuant to the California Business and Professions Code, Section 805.~~

~~K.~~F. Automatic Termination, Suspension or Limitation

1. A Practitioner shall inform the CMO promptly, and in writing, of any change in his or her compliance including, without limitation, professional license status, eligibility to participate in any federal health care program, including Medi-Cal or Medicare, compliance with CalOptima requirements for professional liability insurance, or conviction of a felony.

2. The Practitioner also must inform the CMO pursuant to this ~~section~~Section, if he/she is listed in the ~~Medicare Sanction Activity Report; is terminated~~OIG List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) list, or ~~suspended by, or becomes ineligible for,~~the Medi-Cal ~~participation; is convicted of a felony; or ceases to comply with CalOptima requirements for professional liability insurance.~~Suspended and Ineligible Provider List).

3. In the following instances, the Practitioner's participation may be terminated, suspended, limited, restricted, or placed on probation as described, and such action shall be final, without any of the procedural rights described in ~~the~~ CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. Further, any other action required by CalOptima policies and contractual requirements with respect to the Practitioner's participation in (including through the ~~health networks~~Health Networks) shall be taken as applicable.

   a. Licensure

      i. Whenever a Practitioner's license or other legal credential authorizing practice in California is revoked, suspended, or lapses, the Practitioner's participation shall automatically be terminated as of the date such action becomes effective.

      ii. Whenever a Practitioner's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, the Practitioner's participation with shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term, at least.

      iii. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her participation status with CalOptima shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term, at least.

      iv. Whenever a Practitioner's license or other legal credential is suspended, the Practitioner's participation shall be suspended, at least for the term of the suspension.

   b. Controlled Substances

      i. Whenever a ~~CalOptima Direct~~ Practitioner's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, or has expired, the Practitioner shall

automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.

ii. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term.

c. Medicare/Medi-Cal

i. If a Practitioner is suspended or excluded from participation or otherwise becomes ineligible to participate in Federal or State health care programs including, without limitation, the Medicare or Medi-Cal program, the Practitioner's participation shall automatically be terminated as of the effective date of the sanction.

d. Conviction of a Felony

i. A Practitioner who is convicted of any felony shall immediately and automatically be suspended. Such suspension is effective on conviction and does not await the conviction becoming final.

e. Professional Liability Insurance Eligibility

i. If, for any reason, a Practitioner fails to maintain professional liability insurance as required by CalOptima, the Practitioner's participation shall automatically be suspended until the Practitioner is covered by professional liability insurance acceptable to CalOptima.

~~A Practitioner whose participation is automatically suspended or terminated shall not be entitled to the procedural rights set forth in CalOptima Policy GG.1616Δ: Fair Hearing for Practitioners, unless the suspension is reportable under California Business and Professions Code, Section 805~~

~~L. Interviews~~

~~1. An interview shall neither constitute nor be deemed a "hearing," as that term is used in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. It shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable to hearings.~~

~~2. At the Practitioner's request, CalOptima shall be required to grant the Practitioner an interview only when so specified in this policy. In all other cases where CalOptima has before it an adverse recommendation as defined in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, it may, but shall not be required to, offer the Practitioner an interview.~~

~~a. In the event an interview is granted, the Practitioner shall be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto.~~

~~b. A record of the matters discussed and findings resulting from such interview shall be made.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, Section 805
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Compliance Plan
~~A.~~G. CalOptima Quality Improvement Program
~~B. CalOptima Compliance Plan~~
~~C. 2013 NCQA Standards for Credentialing~~
~~D. CalOptima Policy AA.1000: Glossary of Terms~~
~~E.~~H. CalOptima Policy GG.~~1609Δ: Credentialing and Recredentialing~~1611: Potential Quality Issue Review Process
~~F.~~I. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
~~G.~~J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~H.~~K. CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting
~~I.~~L. CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

~~Not Applicable~~
None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615Δ	CalOptima Direct Corrective Action Plan for Practitioners	
Revised	03/01/2013	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	TBD	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP):	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Credentialing and Peer Review Committee	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Any Complaint or dispute, other than an organization or coverage determination or late enrollment penalty determination, expressing dissatisfaction with the manner in which CalOptima, its providers or delegated entities provides health care services, or the operations, activities, or behavior, regardless of whether any remedial action can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	A beneficiary enrolled in a CalOptima program.
Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing decision
Potential Quality Issue(s)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Back to Agenda Back to Item

Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

1

Policy:	GG.1615Δ
Title:	**Corrective Action Plan for Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	04/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the appropriate corrective action process that CalOptima shall use for Practitioners, including routine monitoring, investigation, and corrective action related to his or her clinical practice.

II. POLICY

A. The Quality Improvement Committee (QIC) oversees CalOptima's quality improvement activities. CalOptima's Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are responsible for the Quality of Care and service provided by CalOptima.

B. The CalOptima's CMO or his or her physician Designee working through, as appropriate, such standing or ad hoc peer review committee as CalOptima may from time to time establish, shall design and implement an effective quality program for the following purposes:

1. To monitor and assess the quality of professional practice of all Practitioners; and

2. To promote high quality of practice by providing education and counseling, issuing letters of admonition, warning or censure, as necessary; and requiring routine monitoring when deemed appropriate by CalOptima or the CalOptima Credentialing and Peer Review Committee (CPRC).

C. CalOptima may conduct an investigation and initiate corrective action against a Practitioner in any Health Network, including to investigate Member complaints and ensure the safety of CalOptima Members.

D. CalOptima shall take corrective action, for a non-medical and medical disciplinary cause or reason, in accordance with the terms and conditions of this Policy.

E. Corrective actions may be imposed based on administrative or clinical findings. Certain investigations and corrective actions (*e.g.*, restriction of members or services) taken on the basis of a medical disciplinary cause or reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB).

Back to Agenda Back to Item

F. CalOptima shall implement any suspension or restriction imposed on a Practitioner for a medical disciplinary cause or reason in accordance with CalOptima Policy GG.1658

G. CalOptima shall notify a Practitioner, in writing, in accordance with that Practitioner's contract, but in no case less than sixty (60) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.

H. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners with a corrective action process when the Health Network takes or proposes action including routine monitoring, corrective action, or investigation related to a Practitioner's clinical practice.

III. PROCEDURE

A. Routine Monitoring

1. All Practitioners, regardless of status, shall be subject to routine monitoring.

2. The Quality Improvement (QI) Department shall conduct regular patient reviews and studies of practice consistent with CalOptima general quality assessment and improvement activities and shall investigate Potential Quality Issues and complaints and Quality of Care incidents in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process, and shall report to the CPRC the results of investigations deemed a Quality of Care issue.

3. The QI Department shall routinely monitor, trend, and analyze Practitioner Potential Quality Issues (PQI) cases and Grievances.

4. If any issues or trends emerge with any Practitioner during the monitoring process, and to assist Practitioners to conform their conduct or Practitioner practice to the standards of CalOptima, the CMO or his or her physician Designee may issue informal comments or suggestions, either orally or in writing or take corrective action as outlined in Section III.C. of this Policy.

5. Informal comments or suggestions shall be confidential and may be issued by the CMO or his or her physician Designee with or without prior discussion with the recipient, and with or without consultation with any CalOptima committee.

6. Such comments or suggestions shall not constitute a restriction of practice prerogatives, and shall not be considered to be a "corrective action" as that term is used in Section III.C.

7. The term "routine monitoring," as used in this section, shall mean review of a Practitioner's practice and may include activities for which the Practitioner's only obligation is to provide reasonable advance notice to any CalOptima committee or representative of certain patient care procedures or other patient care activity.

B. Corrective Action for Medical Disciplinary or Non-Medical Disciplinary Cause or Reason

1. Criteria for Initiation

a. Any person may provide information to the CMO, the QIC or CPRC about the conduct, performance, or competence of any CalOptima Practitioner.

Back to Agenda Back to Item

b. A request for an investigation or action against a CalOptima Practitioner may be initiated by the CalOptima CMO, the CEO, the QIC or CPRC, or the Quality Improvement Department when reliable information indicates that the Practitioner has exhibited acts, demeanor, or conduct reasonably likely to be:

   i. Detrimental to patient safety or to the delivery of quality patient care;

   ii. Unethical;

   iii. Contrary to CalOptima policies, rules, and regulations;

   iv. Contrary to his/her CalOptima agreement (if applicable), or,

   v. Below applicable CalOptima Practitioner standards.

2. Initiation

   a. A request for an investigation must be submitted to the CalOptima CPRC by a person or committee, such as CMO, the CEO, or the QIC, and must be supported by reference to specific activities or conduct alleged to be detrimental to patient safety or to the delivery of quality patient care, unethical, contrary to CalOptima policies or the CalOptima contract (if applicable), or below CalOptima Practitioner standards. If the CPRC initiates the investigation, it shall record the reasons for the investigation in committee meeting minutes.

3. Investigation

   a. If the CalOptima CPRC concludes that an investigation is warranted, it shall direct an investigation to be undertaken.

      i. The CPRC may conduct the investigation or may assign non-medical/administrative investigations to another CalOptima Committee or Department.

      ii. If the investigation is delegated to a body or individual other than the CPRC, such body or individual shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the CPRC as soon as possible. The report may include recommendations for appropriate corrective action.

      iii. If, during the investigation, a reportable corrective action for a Medical Disciplinary Cause or Reason is contemplated, the Practitioner shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual or body deems appropriate.

      iv. The individual or body investigating the matter may, but is not obligated to, interview the persons involved. Such interviews shall not constitute a "hearing," in the manner the term is used in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioner, nor shall any of the procedural rules for hearings apply.

      v. Despite the status of any investigation, the CPRC always retains authority and discretion to take whatever action may be warranted by the circumstances, including summary termination of participation, termination of the investigative process, or other action.

vi. Investigations shall be completed within sixty (60) calendar days unless otherwise directed by the CPRC.

b. In the event of a formal investigation during the credentialing (or recredentialing) process and the provider withdraws his or her application, CalOptima shall determine if an 805 report and/or report to the NPDB is required in accordance with CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

4. Corrective Action

a. Corrective action can be taken as a result of issues found through routine monitoring and subsequent PQI investigations in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review process, or as a result of issues found during formal investigations.

b. The corrective action may be for a non-medical/administrative reason or a medical, disciplinary cause or reason, and if, for a medical disciplinary cause or reason may result in a reportable action.

c. At the conclusion of the investigation, the CPRC shall determine whether to recommend any corrective action, and if so, whether the corrective action recommended is for a non-medical or medical disciplinary cause or reason, and will determine if action is reportable pursuant to CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting.

d. Corrective action for a Non-Medical Disciplinary Cause or Reason

i. If a corrective action is recommended for a "non-medical disciplinary cause or reason" such as customer service-related issues or delays in responding to medical records requests, which the CPRC may take, shall include, without limitation, the following:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant;

b) Sending the Practitioner a community best practice letter;

c) Recommending Practitioner education;

d) Recommending office staff training;

e) Requesting a written Corrective Action Plan (CAP), with appropriate time frames for correction, from the Practitioner demonstrating how the issue will be prevented in the future;

f) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action; or

g) Taking other actions deemed appropriate under the circumstances, including, but not limited to, closing physician panels or freezing specialist referrals.

ii. A corrective action for a "non-medical disciplinary cause or reason" shall not constitute a restriction of practice prerogatives, shall not be considered to be a reportable

Back to Agenda Back to Item

corrective action for a "medical disciplinary cause or reason" as that term is used in Section III.C.4.e. of this Policy, and shall not give rise to hearing rights as outlined in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

iii. If no improvement is found after the "non-medical disciplinary" corrective action is taken within the specified time frame, and the issue addressed in the action is a contractual requirement, the CPRC may escalate the case to CalOptima's Office of Compliance for further action.

e. Corrective action for a "Medical Disciplinary Cause or Reason"

i. If a corrective action is recommended for a "medical disciplinary cause or reason," CPRC may recommend one or more of the following actions:

a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

b) Sending the Practitioner a community best practice letter.

c) Recommending Practitioner education.

d) Recommending a written Corrective Action Plan from the Practitioner clearly demonstrating how the issue will be prevented in the future.

e) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or his or her physician Designee, the CPRC, or the QIC from issuing informal written or oral warnings outside of the mechanism for corrective action.

f) Recommending mandatory participation in: UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP).

g) Imposing, or the Practitioner's voluntarily acceptance of, a suspension of or restrictions on a Practitioner's provision of services to CalOptima Members.

h) Terminating the practitioner's participation in CalOptima's network.

ii. Actions taken for a "Medical Disciplinary Cause or Reason" may require reporting to the California Medical Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting. Reporting under that policy may also be required upon resignation or a leave of absence by a Practitioner from participation in CalOptima programs after notice of an investigation initiated for a "Medical or Disciplinary Cause or Reason."

iii. For an action that must be reportable under Section 805/809.1 hearing eligible, as described in CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network, include medical disciplinary cause or reasons such as:

Back to Agenda Back to Item

a) Incompetence;

b) Gross deviation from the standard of care;

c) Self-prescribing or self-administering controlled substances;

d) Abusing drugs or alcohol;

e) Repeated acts of excessive prescribing or providing controlled substances, and

f) Sexual misconduct with a patient.

iv. If the investigation concludes there is nothing of merit, no corrective action will be taken.

C. Subsequent Actions

1. If the CPRC recommends any reportable corrective action which would entitle a Practitioner to request a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, the CPRC shall give the Practitioner written notice of its recommendation, as provided in the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners prior to imposing such action. A copy of that notice shall be sent to the QIC for informational purposes only. The CPRC shall also provide notice to CalOptima's Office of Compliance and to Legal Affairs. The written notice shall include:

a. The reasons for the action;

b. The standards and profiling data used to evaluate the Practitioner; and

c. Information regarding the Practitioner's appeal rights.

D. CPRC

1. Any CPRC action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIC.

2. If the CPRC does not recommend any corrective action which would entitle the CalOptima Practitioner to a hearing, pursuant to CalOptima Policy GG.1616Δ: Fair Hearing for Practitioners, the CPRC shall either file its report with a recommendation of no further action or take the action that is not reportable.

3. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These medical disciplinary causes or reasons covered by Section 805.01 are:

a. Incompetence;

b. Gross deviation from the standard of care;

c. Self-prescribing or self-administering controlled substances;

d. Abusing drugs or alcohol;

e. Repeated acts of excessive prescribing or providing of controlled substances; and
f. Sexual misconduct with a patient.

E. Action Initiation by QIC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIC may direct the CPRC to initiate investigation or disciplinary action.

2. If the CPRC fails to take action in response to that direction from the QIC, the QIC may initiate corrective action.

F. Automatic Termination, Suspension or Limitation

1. A Practitioner shall inform the CMO promptly, and in writing, of any change in his or her compliance including, without limitation, professional license status, eligibility to participate in any federal health care program, including Medi-Cal or Medicare, compliance with CalOptima requirements for professional liability insurance, or conviction of a felony.

2. The Practitioner also must inform the CMO pursuant to this Section, if he/she is listed in the OIG List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) list, or the Medi-Cal Suspended and Ineligible Provider List).

3. In the following instances, the Practitioner's participation may be terminated, suspended, limited, restricted, or placed on probation as described, and such action shall be final, without any of the procedural rights described in CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. Further, any other action required by CalOptima policies and contractual requirements with respect to the Practitioner's participation in (including through the Health Networks) shall be taken as applicable.

a. Licensure

i. Whenever a Practitioner's license or other legal credential authorizing practice in California is revoked, suspended, or lapses, the Practitioner's participation shall automatically be terminated as of the date such action becomes effective.

ii. Whenever a Practitioner's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, the Practitioner's participation with shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term, at least.

iii. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her participation status with CalOptima shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term, at least.

iv. Whenever a Practitioner's license or other legal credential is suspended, the Practitioner's participation shall be suspended, at least for the term of the suspension.

b. Controlled Substances

i. Whenever a Practitioner's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, or has expired, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.

ii. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term.

c. Medicare/Medi-Cal

i. If a Practitioner is suspended or excluded from participation or otherwise becomes ineligible to participate in Federal or State health care programs including, without limitation, the Medicare or Medi-Cal program, the Practitioner's participation shall automatically be terminated as of the effective date of the sanction.

d. Conviction of a Felony

i. A Practitioner who is convicted of any felony shall immediately and automatically be suspended. Such suspension is effective on conviction and does not await the conviction becoming final.

e. Professional Liability Insurance Eligibility

i. If, for any reason, a Practitioner fails to maintain professional liability insurance as required by CalOptima, the Practitioner's participation shall automatically be suspended until the Practitioner is covered by professional liability insurance acceptable to CalOptima.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, Section 805
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Compliance Plan
G. CalOptima Quality Improvement Program
H. CalOptima Policy GG.1611: Potential Quality Issue Review Process

I. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
K. CalOptima Policy GG.1657Δ: Medical Board and NPDB Reporting
L. CalOptima Policy GG.1658Δ: Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615Δ	CalOptima Direct Corrective Action Plan for Practitioners	
Revised	03/01/2013	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	TBD	GG.1615Δ	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP):	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Credentialing and Peer Review Committee	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Any Complaint or dispute, other than an organization or coverage determination or late enrollment penalty determination, expressing dissatisfaction with the manner in which CalOptima, its providers or delegated entities provides health care services, or the operations, activities, or behavior, regardless of whether any remedial action can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	A beneficiary enrolled in a CalOptima program.
Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing decision
Potential Quality Issue(s)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Back to Agenda Back to Item

Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

1

Policy:	GG.1658Δ
Title:	**Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the process that CalOptima shall use to impose a summary suspension or restriction on a Practitioner for a Medical Disciplinary Cause or Reason.

II. POLICY

A. Actions to suspend or restrict a Practitioner for a Medical Disciplinary Cause or Reason shall be conducted in accordance with the terms and conditions of this Policy.

B. Actions taken on the basis of Medical Disciplinary Cause or Reason shall be reportable under Section 805 of the California Business and Professions Code and to the National Practitioner Data Bank (NPDB) in accordance with CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

C. CalOptima shall notify a Practitioner in writing of a decision, which shall include reasons, standards, and data used to make such decisions to suspend, restrict, or terminate the Practitioner in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, within fifteen (15) days of final decision or recommendation by CPRC.

D. Health Networks shall have policies and procedures consistent with this policy that provide Practitioners with a pre-defined process when the Health Network takes or proposes action including summary suspension, automatic suspension, or limitation or termination related to a Practitioner's clinical practice.

III. PROCEDURE

A. Summary Suspension or Restriction

1. Whenever the failure to immediately suspend or restrict a Practitioner's practice in CalOptima may result in imminent danger to the health of any individual, the Credentialing and Peer Review Committee (CPRC), CalOptima Chief Medical Officer (CMO) or his or her physician Designee, shall have the authority to summarily suspend or restrict a contracted Practitioner's practice prerogatives.

Back to Agenda Back to Item

2. Any suspension or restriction imposed on a Practitioner for a Medical Disciplinary Cause or Reason shall include any notices or reporting required by CalOptima Policies GG.1616Δ: Fair Hearing Plan for Practitioners and GG.1657Δ: Medical Board and NPDB Reporting.

3. If the CPRC does not ratify such a summary suspension within two (2) CalOptima business days, the summary restriction or suspension shall terminate automatically.

4. Any restriction or suspension is subject to ratification by the CPRC. When such ratification is required, the Members shall be notified of the summary suspension immediately, both orally and in writing.

5. The CMO or designee shall file a report with the relevant agency within fifteen (15) days after the CPRC makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805 of the California Business and Profession Code, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs a. to d.. inclusive, may have occurred, regardless of whether a hearing is held pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners. This report is in addition to any report that may be required under Section III.A.5.b. A Practitioner subject to reporting under this Section shall receive a notice of the proposed action as set forth in California Business and Profession Code Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to this Policy.

   b. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or to the public, or the extent that such use impairs the ability of the licentiate to practice safely.

   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be make in any complaint that may implicate these provisions.

   d. Sexual misconduct with one or more patients during a course of treatment or an examination.

B. Initiation of Summary Action

1. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall immediately give oral and written notice, via certified mail, to the Practitioner and also shall notify, in writing, the

Back to Agenda Back to Item

CMO, Chief Executive Officer (CEO), CPRC, and Quality Improvement Committee (QIC) within five (5) calendar days after such imposition of such suspension. The notice shall include the following:

a. Proposed action against Practitioner by the peer review body, which if adopted, shall be taken and reported pursuant to Section 805;

b. The final proposed action;

c. The Practitioner's right to request a hearing on the final proposed action pursuant to CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; and

d. The time limit to request such a hearing.

2. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These medical disciplinary causes or reasons covered by Section 805.01 are:

a. Incompetence;

b. Gross deviation from the standard of care;

c. Self-prescribing or self-administering controlled substances;

d. Abusing drugs or alcohol;

e. Repeated acts of excessive prescribing or providing of controlled substances; and

f. Sexual misconduct with a patient.

3. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth in the notice.

4. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's Members shall be promptly assigned to another Practitioner considering, where feasible, the wishes of a Member in the choice of a substitute Practitioner.

C. CalOptima CPRC Action

1. Within two (2) CalOptima business days, after such summary restriction or suspension has been imposed, a meeting of the CPRC shall be convened to review and consider the action.

2. Notice provided to the CPRC of the summary action shall serve as a request for an investigation carried out pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

3. The CalOptima CPRC shall provide notice to the Practitioner that he or she may participate in the CPRC review and make a statement concerning the issues under investigation, on such terms and conditions as the CPRC may impose. In no event shall any such meeting of the

Back to Agenda Back to Item

CPRC, with or without the Practitioner, constitute a "hearing" nor shall any of the procedural rules for hearings apply, nor shall either party be represented by counsel.

4. The CPRC may modify, continue, or terminate the summary restriction or suspension.

5. The CPRC shall provide the Practitioner with notice of its decision.

6. The corrective action investigation shall be completed promptly to ensure any hearing on the summary suspension or restriction and corrective action can be commenced within the sixty (60) calendar day limit after a hearing on a summary suspension is requested. However, because of the summary nature of the action, reasonable efforts should be made to complete the investigation and to schedule the hearing as promptly as is feasible under the circumstances and as permitted by relevant law.

D. Procedural Rights

1. The Practitioner shall be entitled to hearings and appeals procedures pursuant to the CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if the summary restriction or suspension is not promptly terminated by CPRC.

2. Any suspension that exceeds fourteen (14) calendar days shall be reported to the Medical Board of California in accordance with CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Business and Professional Code Section 809.1
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Compliance Plan
G. CalOptima Quality Improvement Program
B. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
C. CalOptima Policy GG.1657Δ: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting
D. Business and Professions Code §§ 805.01 and 809.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	TBD	GG.1658Δ	Summary Suspension or Restriction of Practitioner Participation in CalOptima's Network	Medi-Cal OneCare OneCare Connect PACE

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	A beneficiary enrolled in a CalOptima program.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Back to Agenda Back to Item

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021
Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

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Committee Overview
The Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee (PMAC) meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is primarily comprised of PACE participants.

PMAC Meeting December 16, 2020

Updates from the Director
Director Elizabeth Lee thanked PMAC members for joining the second virtual committee meeting. Members received updates on the current status of the program. The PACE Center continues to be closed to visitors but remains open Monday through Friday for clinic and skilled rehabilitation appointments. Participants receive wellness kits delivered to their residences 1–2 times per month. Director Lee reminded members that an on-call physician is available during non-business hours. Members were advised of the availability of COVID-19 antibody testing to all interested participants, and the clinic continues to offer COVID-19 testing to participants.

Feedback on PACE Wellness Kits
Director Lee requested feedback from members on the wellness kits. Members responded that they received a scale this month and felt this was beneficial. Members expressed appreciation for the kits.

Overview of Transportation Services
Upon request from members at the previous meeting, Secure Transportation Manager Patrick Estrada provided an overview of transportation services. To contact a transportation representative, participants should call the number on the magnet included in the December wellness kit.

PMAC Member Forum

- One participant shared that he was very proud to be included in the recent KABC7 news segment highlighting CalOptima PACE.
- A participant asked when the COVID-19 situation will end. PACE Quality Improvement Manager Eva Elser responded that vaccines have arrived in Orange County, but the date for participants to return to the PACE center remains unknown.
- A participant expressed satisfaction with transportation services. He stated that it is working very well and picking him up on time. His issues with home health, dialysis and transportation have been resolved.

Back to Agenda

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021

Quality Improvement Committee First Quarter 2021 — Update

Summary

- Quality Improvement Committee (QIC) met on October 13, 2020, November 10, 2020, and December 8, 2020.
- The following subcommittees reported to QIC in Quarter 4 (Q4):
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Utilization Management Committee (UMC)
  - Credentialing and Peer Review Committee (CPRC)
  - Member Experience Committee (MEMX)
  - Grievance & Appeals Resolution Services Committee (GARS)
  - Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PACE QIC)
- Accepted and filed minutes from the following committees and subcommittees:
  - WCM CAC meeting minutes: August 18, 2020 and September 22, 2020 Ad Hoc
  - UMC meeting minutes: August 27, 2020
  - MEMX meeting minutes: October 8, 2020
  - GARS meeting minutes: August 26, 2020
  - PACE QIC meeting minutes: July 21, 2020, and August 25, 2020
  - 2020 Quality Improvement (QI) Work Plan Q3

QIC Highlights

- **Quality Program Highlights**
  - **Homeless Health Initiatives (HHI):** Clinical Field Teams (CFT), Homeless Response Team (HRT) and Mobile Units
    - Debra Kegel presented an update on a pilot program that was launched in April 2019 and has been extended into 2021. HHI has provided care in a variety of options to members experiencing homelessness. Through June 2020, there were 476 internal referrals for outreach and 1505 face-to-face contacts made with people experiencing homelessness. Current initiatives taking place include: Be Well OC, Whole Person Care (WPC), Recuperative Care and Medical Respite Care and Housing Supportive Services, Clinical Field Team, Homeless Response Team, Homeless Coordination at Hospitals and Homeless Clinical Access Program.
  - **Behavioral Health Integration (BHI)** — BH team continues to monitor quality measurement goals related to HEDIS MY 2020. Also, Member Experience Survey related to BH was presented at committee.

Back to Agenda

- Attention Deficit Disorder (ADD) for Medi-Cal for continuation and maintenance phases currently not meeting goal. Proposed intervention to reach providers with a best practice letter. In 2021, the plan is to continue non-compliant providers letter activity and conduct member outreach to improve appointment scheduling and adherence. However, the committee provided feedback and recommended to postpone the letter campaign in consideration of COVID-19 pandemic provider challenges.
- Antidepressant Medication Management (AMM) rates the last four quarters fell below goal, especially for Medi-Cal. A depression brochure and video were completed and posted to CalOptima website. In 2021, the plan is to educate providers and members on AMM adherence requirements. Dr. Sweidan suggested improving members' access to providers would help this measure, which has been challenging.
- Follow-up after Hospitalization (FUH) for OneCare Connect, continues to be a challenging measure. In 2021, the plan is to visit the top six hospitals with highest OneCare and OCC psychiatric admissions, and continue member outreach post-discharge to coordinate follow-up appointments.
- Member Experience with BH was presented summarizing members' satisfaction with BH services received in 2019. The survey had two parts: Mental Health (MH) Services capturing medication and therapy services; and Applied Behavior Analysis (ABA) services. The satisfaction rates did not meet benchmark of 85%, however, there were opportunities identified with the questions and methodology of the survey for future reference. Recommendations included improving survey questions, include question on telehealth services, and administer surveys closer to dates of service.
- In November, Dr. Edwin Poon presented the BHI Incentive Program, funded by DHCS under Prop 56. CalOptima was selected out of 12 approved applications. The objective of the program is to incentivize plans to improve physical and behavioral health outcomes, care delivery efficiency and member experience. The next step is to complete program readiness requirements, finalize quality metrics and execute Memorandum of Understanding (MOU). Regular updates will be shared with the committee.

➢ **Preliminary Quality Improvement Evaluation for 2020**

- In 2019–20 the priority quality measures for DHCS Managed Care Accountability Set (MCAS) were Well-Care Visits, Preventive Screenings, and Star Measures such as Access to Primary Care and Comprehensive Diabetes Care.
- Member and provider incentives were drivers for improvement in 2020, as well as an increased collaboration with health networks to improve information and data capture.
- In 2021, recommendations include health rewards program, implementation of mobile texting and virtual modes of communication, as well as prioritizing data bridging efforts for improved data capture.

Back to Agenda

- Final evaluation for 2020 will be presented at the January QIC.

➢ **Population Health Management Equity Analysis** — Comprehensive analysis of health and health care disparities linked to social, economic and environment was presented. CalOptima's diverse ethnic membership, along with health disparities among races and ethnicity, emphasized the societal inequity toward the Black population. CalOptima aims to identify opportunities to address population health disparities and promote health-equity for all CalOptima members.

➢ **Post-Acute Infection Prevention Quality Incentive** — In Q3 due to COVID-19, on-site visits were suspended. Facilities continue to be monitored and contacted via phone and email. Four PIPQI facilities continue to be COVID free.

➢ **QIPE/PPME — Case Management** reports the OC and OCC Health Risk Assessment met outreach timeliness and completion rates. Oversight of ICP bundles continue to meet goal, and ICP completion within 90 days of enrollment continue to show improvement despite pandemic impact.

➢ **Pharmacy Update —** Pharmacy announced DHCS delayed transition to Medi-Cal Rx to April 1, 2021.

o **UMC**

➢ UM report was presented to committee, including membership summary, operational performance and outcome measures. No major trends or outliers identified. Pharmacy, BHI and LTSS authorization turnaround time met. Bed days for OCC slightly above goal. Over/under utilization dashboard will be sent to UMC quarterly for input and discussion. Q3 2020 over/under utilization data reported at Q4 UMC.

o **GARS**

➢ Member and Provider Complaints Q3 2020 — Medi-Cal member grievances increased by 43%, member appeals increased 22%, provider appeals decreased 17%.

- Quality of Service continues to be the highest grievance category.
- BH grievances increased by 31% in Q3, however, Q2 grievances appear to be lower due to utilization decrease during onset of COVID-19 pandemic.
- Outliers include 40% billing increase attributed to COVID-19 testing. Access grievances increased by 72% attributed to appointments/office staff accessibility during COVID-19, which resulted in telehealth-only appointments and reduced office hours.

➢ OCC member grievances increased by 52%, member appeals decreased 11%, and provider appeals decreased 7%.

- Access, quality of care and quality of service continues to be the top three grievance categories.
- OCC BH grievances decreased significantly from the beginning of 2020.
- Outliers include billing and transportation, mainly due to COVID-19 pandemic-related complaints.

➢ OC member grievances remain very low in volume, with no major trends or outliers.

o **Whole-Child Model — Clinical Advisory Committee (WCM CAC)**

- Dr. Nguyen presented a summary of WCM CAC meetings on August 18, 2020, and ad hoc meeting September 22, 2020. The committee charter was updated and approved. Also, WCM quality measures were presented at the CAC which included a summary of utilization measures, Customer Service and GARS. Presentations by Pharmacy and Virtual Care Strategy were also summarized.

- **Member Experience Subcommittee (MEMX)**
  - **Health Network Member Experience Performance** — CalOptima continues to monitor HN performance related to member experience through CAPHS scores. HNs with CAHP scores below 2.5 are asked to implement initiatives to improve member experience using Plan-Do-Study-Act (PDSA) methodology. Based on MY2019, CalOptima Community Network, Heritage-Regal Medical Group, AMVI Care Health Network and Family Choice Medical Group are being asked to complete the PDSA to help drive improvement in member experience.
  - **Virtual Care Strategies** — Since texting campaigns to Medi-Cal members require DHCS approval, mPulse member texting COVID-19 and Flu Shot campaigns were cancelled for November 2020. We are in the process of seeking final approval of texting policy for DHCS to obtain approval for future campaigns. E-consult RFP has been issued and vendor selection on target for Q1 2021. Continue contracting and onboarding BH and specialist providers/groups that offer virtual care services.
  - **Timely Access** — CalOptima issued timely access provider letters in October 2020 to communicate and enforce provider compliance with timely access standards. Although provider complaints surfaced due to letters being sent during pandemic, CalOptima is moving forward with fielding the 2021 Timely Access Survey with a hybrid methodology. In-office wait time surveys will begin in January 2021 for members who had recent visits to the doctor.
- **Credentialing and Peer Review Committee (CPRC)**
  - **Credentialing activity** at the plan level include 234 initial and 567 recredentialing files; 0.3% of the recredentialed files exceeded the 36-month required time frame.
  - **Ongoing monitoring** for CalOptima, including HNs is conducted monthly. This includes medical licensing board actions as well as exclusion and preclusion activity. Any adverse activity identified is communicated to HNs and monitored monthly. Credentialing now monitors DHCS Restricted Provider Database, which identifies providers with claims issues. A new process is being developed similar to the CMS Preclusion list and will be rolled out to HNs.
  - **Council for Affordable Quality Healthcare (CAQH)** is a credentialing application tool used by Credentialing to capture provider information. This new tool allows providers to enter credentialing elements once and attest to accuracy quarterly. Since the implementation of the tool in 2019, adoption increased from 45% to 96% with those credentialed directly with CalOptima.
  - **Potential Quality Issues (PQI)** recently adopted a new process in response to the 2020 DHCS medical audit. The changes made to the GARS/PQI process require medical director review of quality related grievances prior to becoming a PQI. Medical director's clinical

Back to Agenda

recommendations are incorporated into the member grievance resolution letter. The number of PQIs opened as a result of member grievance have declined from average of 115/month to 75 in November 2020. Staff anticipate a further decrease in number of PQI's in future months.

Attachments

2020 Quality Improvement Work Plan Q3

Back to Agenda

2020 QI Work Plan
3Q Update

2020 QI Work Plan Element Description	Planned Activities	**Staff Responsible**	Department	**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						
2020 QI Annual Oversight of Program and Work Plan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Betsy Ha	Quality Improvement	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2019 QI Program Evaluation	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Betsy Ha	Quality Improvement	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2020 UM Program	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Mike Shook	Utilization Management	2020 UM Program approved: QIC 4/21/20		
2019 UM Program Evaluation	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Mike Shook	Utilization Management	2019 UM Evaluation approved: QIC 4/21/20		
Population Health Management Strategy	Review and adopt on an annual basis	Pshyra Jones	Quality & Population Health Management	Population Health Management Strategy was written in May of 2019, and presented at QIC in August of 2019. The annual review of the strategy is in progress, and will be presented at QIC 8/11/2020.	Strategy will be presented at QIC in Q2 (8/11/20).	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Miles Masastugu, MD/ Esther Okajima/L. Guest	Quality Improvement	CPRC update on Q3 activity was presented to QIC on 12/08/2020. The initial and recredentialing, and on-going monitoring for the Plan was presented. In Q3, 99.7% of the recredentialing files were timely. There were no 805 disciplinary action reported by the Plan PQI data for quality of service cases were presented. These cases represent 93% of the PQIs and are determined to be no quality of care or a service-related issue. The greatest numbers of these cases continue to be related to medical care from the member's perception. Quality of Care cases were also presented, and medical care is also the greatest category, specifically related to mismanaged care and diagnosis issues. In Q2, the Plan received a DHCS Correction Action Plan (CAP).The findings included: 1)The Plan did not correctly identify and process Quality of Care grievances, 2)The Plan did not immediately submit all of the Quality of Care Grievances to the its medical director for action, and 3)The Plan sent resolution letters to members without completing the investigation process to resolve both Quality of Service and Quality of Care grievances. In Q3, a workflow of the new GARS/PQI process to address the CAP from DHCS was outlined and presented to QIC. COVID-19 continued to impact the oversight for nursing facilities and CBAS. In Q2 and Q3, the staff began a virtual process for oversight of the nursing facilities for CHDP reviews completed in Q4 2019 and Q1 2020. FSR/PARS: A total of 14 virtual FSRs were performed in Q3. On-site audits (FSR/MRR) were resumed in Q3 2020. Preventive measures were established in order for FSR nurses to safely return to the field. On-site PARS reviews will be resumed in Q4 2020. DHCS APL 20-011(GOVERNOR'S EXECUTIVE ORDER N-55-20 IN RESPONSE TO COVID-19) is still in effect. Implementation of the updated DHCS FSR/MRR Tools & Standards are temporarily suspended through the duration of the COVID-19 public health emergency and for an additional six months following the end of the public health emergency.	In Q4, testing of the new GARS/PQI process will be performed and modifications of the process will be identified. Full implementation of the new process will occur in Q4. It is anticipated that the number of Quality of Service PQIs will decline as a result of the new process.	
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.	Mike Shook	Utilization Management	UMC presented 2020 1st quarter and annual trends update to QIC on 7/14/20. QIC accepted and filed UMC 5/28/20 meeting minutes. AMR Board Certified Specialist list was reviewed by QIC. Update to QIC included: Member Summary ending March 2020, 1Q 2020 Operational Performace, 1Q 2020 Utilization Outcomes, WCM - NICU & PICU July 2019-March 2020, In-patient and DME July 2019-Mach 2020 Update, Over/Under Utlization Monitoring, 1Q 2020 O/U Dashboard, BMSC Update, Pharmacy, BHI.	UMC is scheduled to present to QIC on 10/13/20.	

2020 QI Work Plan
3Q Update

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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 2020 QI Goal of improving CAHPS and Access to Care.	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	Quality Analytics	In Q3, MEMX Committee has reviewed/discussed the following: • MY 2018 HN Quality Improvement Plans and the MY 2019 Medi-Cal HN CAHPS Scores. The committee discussed issuing formal CAPs to consistently low performing HNs and recommended that this item be presented at the Executive Meeting for further guidance. • 2020 DHCS Audit Preliminary Findings and plans for remediation. • Behavioral Health 2020 Member Experience Survey Results • MEMX QI Work Plan Project Updates	In Q4, MEMX Committee has meetings schedule for October and December.	
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.	T.T. Nguyen, MD	Medical Affairs	WCM gave an upate to QIC on 8/11/20.WCM met on May 19, 2019. Pharmacy update on CCS utilization reflected an increased in pharmacy usage.Medical necessity will be considered for continued care for members who meet service needs. Not many grievance have been received as a result of the automatic CoC ending.	The current Member Experience workgroup will continue with the general members and not be a separate WCM CAC workgroup like previously considered. Medi-Cal pharmacy benefit carve-out information which will continue as planned was shared. The next meeting 8/13/2020	
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 Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Ana Aranda	GARS	GARS presented to QIC on 09/08/20 their report of Q2 2020 Medi-Cal Complaints (Member Appeals, Member Grievances, Provider Apprels); Medi-Cal Grievances by Category; Medi-Cal BH Grievances; Outliers/Trends-Medi-Cal Member Grievances;OCC Complaints 1Q/2Q Comparison;OCC Grievances by Category; OCC BH Grievances;OC Complaints; QIC accepted and filed GARS 11/21/19 Meeting Minutes.	As providers reopen their offices or provide telehealth visits, members are being scheduled for care and services. CalOptima continues to monitor the availability of providers to ensue adequate access to care. Members continue to be educated on how to contact CalOptima and get care.	
PACE QIC - Quarterly review and update of PACE QIC activities	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Miles Masatsugu, MD	PACE	PACE QIC presented to QIC on 8/11/20 and update and presented Q2 2020 Meeting Minutes. PACE member's average age is 70-80. Prior to COVID-19 members were coming to the center. After, PACE is experiencing members reluctant to come to the center. They are setting up face to face platform visits. 30% of the population did not have either the equipment or bandwidth for virtual visits. It was very challenging to get members set up. Another 35% simply did not have an interest to access via telehealth. Participant family support was another challenge and took up a great deal of staff support. A significant part of member population either cannot or does not want to participate in face to face telehealth	PACE QIC will give an upate to QIC on 10/13/2020. Will bring July/Aug Meeting minutes.	

2020 QI Work Plan
3Q Update

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Quality Withhold for OCC	Monitor and report to QIC	Kelly Rex-Kimmet/ Sandeep Mital	Quality Analytics	100% of Quality Withhold Dollars were received in September. For CY2018 (DY4), CalOptima passed 7 of 8 measures in the OneCare Connect Quality Withhold program for a final passing score of 87% which qualified us to receive 100% of the quality withhold dollars back.	P4V team has completed the calculations for the withhold amount to be reimbursed for each health network based on their performance on the measures stipulated by CMS. Payments will be sent to HN's via electronic fund transfer after validation by Finance.	
Quality Program updates (Health Network Quality Rating, MCAS, P4V)	**Varies per measure**. Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Kelly Rex-Kimmet/ Paul Jiang	Quality Analytics	CalOptima was recently recognized by DHCS as the only health plan in CA to achieve all of the new minimum performance levels for the MCAS measure set. For MY 2019, the MPL was raised from the 25th to 50th National Medicaid benchamark for 17 measures.	Awaiting decision from DHCS regarding any changes to the MCAS measure set for MY2020 or MY2021. P4V payments based on MY2019 performance in progress.	
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; 2) Improving well-care visits for children in the 15 months of life (W15) **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% **OCC QIP:** Improving Status Use (SPD) **OCC PIP:** Member with ICP with documented discussions of care goals - Concluded 4/2020. **PPME (OC):** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC):** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents	Helen Syn/ Mimi Cheung/Sloane Petrillo/ Cathy Osborn	Population Health Mgmt./Case Management	**PPME (OC)** HRA outreach completion: Annual: JUL-100%/AUG-100%/SEP100%; Initial: JUL-100%; AUG/SEP IP; HN MOC Oversight: JUL-98.6%/AUG-99.64%/99.5% **QIPE (OCC)** HRA outreach completeion: Annual: JUL-99%/AUG-97%/SEP-98%; Initial: JUL 00%/AUG-100%/SEP-100% ICP 90-day completion Q3 79%; HN MOC oversight: Annual: JUL-97.7%/AUG-97%/SEP-97%; Initial: JUL-88.3%/AUG-95%/SEP-94.5% **MC PIP:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County 2) Improving well-care visits for children in the 15 months of life (W15) Closed out at the end of Quarter 2, 2020 due to COVID. **OCC PIP:** Member with ICP with documented discussions of care goals - **PIP concluded 4/2020.** **OCC QIP:** Improving Statins Use for Patients with Diabetes	MC PIPs will start again in Quarter 4, 2020. Proposals for topics are due to DHCS in November. CalOptima has chosen to continue with the same topics with updates on baseline data. The child/adolescent PIP topic will continue to focus on improving well-child visits for children in the first 15 months of life. However, the measure has changed to well-child visits in the first 30 months of life, with W15 as a submeasure now. OCC QIP: Continue with intervention and tracking QIPE/PPME: Continue to monitor/track.	

Back to Agenda

2020 QI Work Plan
3Q Update

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II. QUALITY OF CLINICAL CARE- ADULT WELLNESS						
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	1) Continue Homeless Clinical Access Program (HCAP) program. This program started in late 2019 and will be available for members in 2020 2) Support health networks and provider offices with targeted outreach (i.e. CalOptima Day activities) 3) Implement the Health Equity PIP to improve access to acute/preventive care services for homeless members. 4) Track the number of homeless members accessing preventive care services at Homeless clinic events, and help transition members back to PCP	Pshyra Jones/ Jasmine Awadallah/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	HCAP program continued with barriers due to the COVID-19 pandemic. Counts were adjusted to include telehealth visits instated during the COVID-19 pandemic. **2020 September Prospective Rate (PR):** MC: 60.40% OC: 86.88% OCC: 85.83% Measure is performing lower than same time last year for all LOBs (MC, OC, OCC)	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations.	
Cervical Cancer Screening (CCS)	1) Implement $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach (IVR, call campaigns, etc.)	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	1) **Targeted mailing to CCS population** initially delayed due to COVID-19 pandemic was dropped Sep 15-18 to **66,362** female Medi-Cal members due for a cervical cancer screening 21-64 years old. the mailing included the CCS incentive form and COVID-19 general disclaimer. **2) # of CCS 2020 member incentives processed as of 9/30/20: 140** 3**) 2020 September Prospective Rate (PR):** MC: 53.62% Measure is performing lower than same time last year.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations.	
Colorectal Cancer Screening (COL)	1) Implement new member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy)	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	**1) # of COL 2020 member incentives processed as of 9/30/20: 7** **2) No-Cost Colorectal Cancer Screening for People 50 and Older article** was printed in Aug Q3 OCC Newsletter, with information on the colorectal cancer screening incentive. 3**) 2020 September Prospective Rate (PR):** OC: 47.13% OCC: 49.27% Measure is performing lower than same time last year for both OC/OCC.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to 2021 QI Workplan strategy. Targeted Mailings and IVR campaigns: Delayed due to COVID-19 precautions	
Breast Cancer Screening (BCS)	1) Implement $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings. Track the number of calls listened to from targeted outreach campaigns (i.e. IVR or direct phone outreach) 5) Track the number of mammograms scheduled through targeted call campaigns.	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	1) Targeted mailing to BCS population initially delayed due to COVID-19 pandemic was dropped Sep 18-21 to **17,862 female Medi-Cal members** due for a breast cancer screening 50-74 years old and to **1,362 OC/OCC members**. The mailing included the BCS incentive form and COVID-19 general disclaimer. **2) # of BCS Medi-Cal 2020 member incentives processed as of 9/30/20: 95** **# of BCS OC/OCC 2020 member incentives processed as of 9/30/20: 11** 3**) 2020 September Prospective Rate (PR):** MC: 54.81% OC: 62.32% OCC: 57.46% Measure is performing lower than same time last year all LOBs.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations.	

2020 QI Work Plan
3Q Update

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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).	1) Visit top 3 hospitals in the first quarter. 2) Outreach to members post discharge to coordinate follow-up appointments. 3) Track the number of members that have a follow up appointment at discharge.	Edwin Poon	Behavioral Health	PR HEDIS Rates Q1: 30-Day 13.79%; 7-Day 6.90%; Q2: 30-Day 32.73%; 7-Day 7.27% Q3: Not available 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Experienced some difficulty reaching members post-discharge. 2) Continued to complete the Psychiatric Transition Summary Form to confirm follow up visits were scheduled. Experienced some difficulties with IP facilities providing discharge notification and information in a timely manner. 3) Weekly BHI clinical rounds meeting with MD, MCM's and PCC to discuss concurrent reviews and internal coordination interventions continued. 4) County has not been billing CalOptima for Medicare covered MH services. CalOptima working with OC HCA to credential providers to ensure that County claims are being processed to capture all data. 5) Updated Guiding Care Script in order for FUH CORE report to pull the required data. FUH CORE report is currently being developed.	Establish tracking method to identify members that did not attend follow-up appointment 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.	1) Develop CORE report and track the numbers of members that filled Rx and their providers. 2) Coordination for members and providers through outreach and assistance with appointment setting and reminders. 2)Track the number of members that have a follow up appointment scheduled.	Edwin Poon	Behavioral Health	PR HEDIS Rates: Continuation and Maintenance Phase Q1: 47%; Q2: 42%; Q3: Not available 1) Pharmacy related intervention placing a 30-day limit for the initial fill of ADHD medication to encourage members to follow up with the prescriber within 30 days continues. This intervention will discontinue at the end of the year due to the new pharmacy benefit carve out beginning 1/1/2021. 2) Created report to track/trend providers with high non-compliance.	1) Update ADHD Provider Cover Letter and ADHD Medication Best Practice Letter. 2) Send letters to high non-compliant providers. 3) Update and distribute member and provider educational materials for ADD.	
IV. QUALITY OF CLINICAL CARE - CHRONIC CONDITIONS						
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	1) Quarterly faxes to Provider offices with lists of members missing an appropriate statin (SPD: any potency statin; SPC: moderate to high potency statin) or members who fall below adherence thresholds (PDC< 80%). (Rx) 2) SPD targeted mailings to members based on list provided from Pharmacy Provider outreach. (PHM) 3) Conduct IVR outreach calls to targeted members. (PHM) 4) Track the number of new members starting appropriate statins medications from targeted outreach list. 5) Track the number of members who were adherent to appropriate statins using calculated PDC rates.	Nicki Ghazanfarpour/ Helen Syn	Pharmacy/Population Health Mgmt.	**Pharmacy Management:** 1. Provider fax interventions completed by Pharmacy Dept for SPD: 563; Successful: 534; Failed: 29 (faxes); 6,918 (members) Total Mbr Count: MCAL: 6,086; OCC: 744; OC: 88 2. Provider fax interventions completed by Pharmacy Dept for SPC: 241; Successful: 226; Failed: 15 (faxes); 533 (members) Total Mbr Count: MCAL: 419; OCC: 102; OC: 12 **PHM:** 1) SPD Member mailing delayed and pushed to October 2) 2020 September Prospective Rate (PR): **SPC:** MC: Adherence Total: 52.83% Therapy Total: 78.99% B OC: Adherence Total: 41.03% Therapy Total: 75.00% L OCC: Adherence Total: 60.37% Therapy Total: 78.21% B Measure is performing better same time last year for MC and OCC but lower for OC. **SPD:** MC: Adherence Total: 47.33% Therapy Total: 68.73% B OC: Adherence Total: 52.35% Therapy Total: 72.65% B OCC: Adherence Total: 60.44% Therapy Total: 78.81% B Measure is performing better same time last year for MC, OC and OCC.	Pharmacy: Continue quarterly faxes and tracking. PHM: Continue quarterly member mailings and tracking. SPD Member mailing delayed to Q3.	
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	1) Quarterly faxes to Provider offices for members missing persistent beta blocker use for a total of 6 months post-ASCVD date. 2) Track the number of members who are persistently using beta blockers 6 months post-ASCVD date.	Nicki Ghazanfarpour	Pharmacy	Provider fax interventions completed by Pharmacy Dept for PBH: 78; Successful: 74; Failed: 4 (faxes); 105 (members) Total Mbr Count: MCAL: 90; OCC: 15; OC: 0	Continue quarterly faxes and tracking.	

2020 QI Work Plan
3Q Update

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Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	**1)** Targeted mailing to CDC-Eye Exam and A1C population initially delayed due to COVID-19 pandemic was dropped Sep 10 to **20,532 Medi-Cal members with diabetes, 260 OC members with diabetes and 2,569 OCC members with diabetes**. The mailing included the A1C Test and Eye Exam incentive forms, an information flier on health coaching, Questions to Ask Your Doctor about Diabetes Medicine informational sheet and a COVID-19 general disclaimer. **CDC A1c Testing:** 2) # of A1c Testing - 2020 member incentives processed as of 9/30/20: 37 **3) 2020 September Prospective Rate** MC: 73.52% OC: 78.26% OCC: 21.05% B Measure is performing better than same time last year for MC and OCC but lower for OC	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. On Hold: Reassessing IVR or mobile texting campaigns to address anticipated continued drops in testing and exams versus potential risks of unchecked diabetes.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)	1) Targeted outreach to members in "emerging risk" category (8.0-9.0) 2) Track the number of completed calls to emerging risk members identified	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	1) Targeted mailing to CDC-Eye Exam and A1C population initially delayed due to COVID-19 pandemic was dropped Sep 10 to **20,532 Medi-Cal members with diabetes, 260 OC members with diabetes and 2,569 OCC members with diabetes**. The mailing included the A1C Test and Eye Exam incentive forms, an information flier on health coaching, Questions to Ask Your Doctor about Diabetes Medicine informational sheet and a COVID-19 general disclaimer. 2)Health coaches continue outreach to members who moved recently from <8% to >8% based on recent lab data to identify the cause for the increase and support efforts to reduce it with behavior modification and/or better medication adherence. **3) 2020 September Prospective Rate (PR) (A1c >8; Adequate Control - (PR):** MC: 34.20% OC: 45.96% OCC: 44.50% Measure is performing better than same time last year for all LOBs	Targeted mailing to go out to all members with diabetes currently not on a Statin medication or not adherent to go out in October 2020. Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Continue health coach outreach to those showing emerging risk with recently identified A1C values >8%	

2020 QI Work Plan
3Q Update

2020 QI Work Plan Element Description	Planned Activities	**Staff Responsible**	Department	**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 HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	**1)** Targeted mailing to CDC-Eye Exam and A1C population initially delayed due to COVID-19 pandemic was dropped Sep 10 to 20,532 Medi-Cal members with diabetes, 260 OC members with diabetes and 2,569 OCC members with diabetes. The mailing included the A1C Test and Eye Exam incentive forms, an information flier on health coaching, Questions to Ask Your Doctor about Diabetes Medicine informational sheet and a COVID-19 general disclaimer. **2)** The Diabetes Eye Exam incentive for 2021 was redesigned to include the question for attestation whether Eye Exam results have been share with PCP from vision specialist to promote communication between specialist and primary care providers. **CDC Eye Exam:** 3) # of Eye Exam - 2020 member incentives processed by 9/30/20: 11 **4) 2020 September Prospective Rate (PR):** MC: 44.99% OC: 55.90% OCC: 57.14% Measure is performing lower than same time last year for MC and OCC and better for OC.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Waiting on IS solution to provide VSP with eligibility file that identifies all CalOptima members with diabetes to permit annual diabetic eye exam without barriers. To reassess continuing the diabetes IVR campaign urging testing and exams due to potential risks of unchecked diabetes.	
V. QUALITY OF CLINICAL CARE - MATERNAL CHILD HEALTH						
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	1) Implement $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments	Ann Mino	Population Health Mgmt.	159 postpartum incentives were approved or in process for Q3. To date for 2020 there have been 328 total postpartum incentives approved or are being process. 312 member Bright Steps postpartum assessments were completed in Q3. For 2020, there has been over 650 member postpartum assessmetns completed through the Bright Steps program.	Continue to track Bright Steps completed postpartum assessments and postpartum incentives. Provider mailing to encourage notification of pregnant members to CalOptima/Bright Steps, to complete a postpartum visit with members and reminder of CalOptima postpartum incentive to Medi-Cal members. Continue to promote Bright Steps and the postpartum incentive through the CalOptima website, provider offices, and member mailings.	
VI. QUALITY OF CLINICAL CARE - PEDIATRIC /ADOLESCENT WELLNESS						
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	Educate providers and members on importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. Track number of educational events on depression screening and treatment.	Edwin Poon	Behavioral Health	PR HEDIS Rates Q1: MC: 34.33%; OC 50.00%; OCC: 47.06% Q2: MC 38.78%; OC 46.15%; OCC 52.94% Q3: Not available 1) Updated educational brochure on depression and the importance of treatment compliance. 2) Depression video published on CalOptima website to support and educate members. 3) No educational events occurred due to COVID-19.	Distribute educational brochure to provider offices for members diagnosed with depression.	

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Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	1) Develop way to load PHQ scores from Guiding Care to HEDIS software. Develop way to capture information (i.e., PHQ scores and scheduled f/u appts) from provider offices. 2) Educate providers on depression screening tools and importance of screening. 3) Educate providers and members on importance of follow up appointments via newsletters/ outreach. 4) Track depression screening scores completed by internal staff in GC. 5) Track number of educational events for depression screening and treatment, and increase # compared to last year.	Edwin Poon	Behavioral Health	PR HEDIS Rates Q1: N/A; Q2: N/A; Q3: N/A 1) Overall, data collection continues to be a challenge because of the lack of mechanisms for capturing provider data. Meetings will continue to address data barriers and develop alternate solutions. 3) Created a depression brochure to be used in members and providers outreach. 4) Depression video published on CalOptima website to support and educate members.	1) Develop a HEDIS reporting tip sheet to educate providers on DSF requirements. 2) Continue to meet with QI/QA team to find ways for collecting data from Health Network providers on depression screenings. 3) Continue to educate providers on the importance of screening their patients for depression and follow-up via provider newsletters. 4) Distribute brochure to provider offices for members diagnosed with depression.	
Well-Care Visits in first 15 months of life (W15)	1) Implement CalOptima Days targeting the W15 population only and track the number of members who engaged in W15 CalOptima Day events. 2) Implement **Member** incentive program for completing 1-3 and 4-6 well-child visits in the first 15 months of life and Track the number of W15 incentives paid out to members 3) Implement **Provider** incentive program for the W15 measures; members must complete 1-3 and 4-6 visits. Track the number of W15 incentives paid out to providers.	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	**1) # of W15 1-3 and 4-6 visit 2020 member incentives processed as of 9/30/20: 1897** **2) 2020 September Prospective Rate (PR):** (W15 all 6 visits) MC 31.59% Measure is performing lower than same time last year. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going into their PCP's office timely.	Due to the COVID-19 pandemic, the quality measures are negatively impacted as members are not accessing timely health care services. Continue to monitor measure and adjust due to anticipated drop in preventative services due to COVID-19 and 2021 QI Workplan strategy.	
Adolescent Well-Care Visits (AWC)	1) Implement $25 member incentive program for adolescents 12-17 years old and Track the number of AWC incentives paid out to members. 2) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events.	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	**1) # of AWC 2020 member incentives processed as of 9/30/20: 6658** 2**) AWC 2020 September Prospective Rate (PR):** **MC: 25.25%** Measure is performing lower than same time last year.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Decision to continue the AWC incentive through Dec 2020, but sunset and discontinue due to the anticipated ineffective impact on large denominator and due to the unexpected surge of incentives draining incentive budget.	

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Children and Adolescents' Access to Primary Care Practitioners (CAP)	1) Targeted outreach campaigns (IVR, call campaigns, etc.) 2) Also see other measure activities: [W15, AWC, IMA, CIS activities] 3) Track number of members who have an office visit after targeted outreach campaigns (i.e. IVR/Text messaging) 4) CAP measures is impacted by the following measures: W15, AWC, IMA, CIS and it's activities.	Pshyra Jones/ Helen Syn/ Mimi Cheung	Population Health Mgmt.	**Child Access to Primary Care (CAP)** **2020 September Prospective Rate (PR) Medi-Cal:** 1. Age 12 - 24 months: 93.00% 2. Age 25 months - 6 years: 70.01% 3. Age 7- 11 years: 80.24% 4. Age 12 - 19 years: 78.46% Measure is performing lower than same time last year for all submeasures.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. However, CAPs appears to be OK for now. Continue to monitor measure and adjust according to CDC recommendations.	
VII. QUALITY OF SERVICE						
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	1) Continue Provider Data Initiative 2) Update the CalOptima Website (Provider Directory) so that providers and services are easily accessible to members. 3) To have HN meet Time and Distance Standards 4) To have HN have at least 1 urgent care enter int he provider directory.	Marsha Choo	Quality Analytics	• CS continues to conduct outbound calls to high risk members to inform members of additional care delivery options such as telehealth and the nurse advice line and practical advice on stay safe during the COVID-19 pandemic. • Member Portal updates include COVID-19 message about self-service. New member registration at an avg. rate of 600 per week. • CalOptima has decided to not renew the contract with this vendor and sunset the project. No provider coaching nor workshops were conducted in this quarter. • Contract executed with MPulse a member texting platform. • RFP for provider directory attestation has been cancelled.	• CS continues to conduct outbound calls to high risk members. • Member Texting campaign for COVID-19 and Flu Shots to begin in Q4. • PR to develop an internal process for provider directory attestation.	
Review of Timely Access - Increase appointment availability	1) Contract with Telehealth vendor and initiate telehealth services for identified specialties. **(Pace Telehealth, BH Virtual Care Visit, After-hour Telehealth)** 2) PCP Overcapacity Monitoring and closing of panels	Marsha Choo	Quality Analytics	• PCP Overcapacity continues to be monitored. Due to COVID-19 pandemic, no panels have been closed. • CalOptima has decided to reallocate the IGT-9 funds from Extended After Hours Initiatives to eVisits and September QAC approved COBAR. • Contract executed with PACE Telehealth Solution (VSee) • Contract executed with Bright Heart, a BH virtual visit platform. • eConsult RFP issued and proposals due at the end of September 2020. • Timely access notification and education letters to non-compliant letters drafted and data file prepped.	• PACE Telehealth Solutions plan to go live in October 2020. • Bright Heart BH Call center to begin referring members in August 2020. • eConsult vendor selection to occur in Q4. • Timely access notification and education letters to non-compliant letters to be mailed in Q4. Contract with vendor to be updated include regular and more real-time monitoring and education.	

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VIII. SAFETY OF CLINICAL CARE						
Plan All-Cause Readmissions (PCR)	1) ~~Complete RFP and select vendor to collect ER data, and reinstate ER discharge program~~ 2) Track # of Members receiving health coaching 3) Track # of member with a hospital admission versus unplanned readmission	M. Shook Helen Syn/ Jocelyn Johnson	Case Management/Population Health Mgmt.	**2020 September Prospective Rate (PR):** MC: 8.40% OC: 6.45% OCC: 12.48% Measure is performing better than same time last year for MC and OC and lower for OCC. **OCC CHF Transition of Care Q2 2020:** 5 members were identified as having an OCC CHF discharge 2 Members were UTC 1 successful outreach was completed 2 Member were dsicharged from SNF	Two vendors have been selected and contracting is underway. Planning and implementation group has met and is preparing for implementation once contracting is complete.	
Opioids Utilization	Interventions: a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards e. Pharmacy Home f. Prescriber Restriction	Kris Gericke	Pharmacy	Goal: Average Morphine Milligram Equivalent (MME)/Member <15.5 1Q19: 13.9 1Q20: 12.0 2Q20: 11.4 3Q20: 10.9	Goal met. Continue interventions and monitoring.	
Post-Acute Infection Prevention Quality Incentive (PIPQI), aka as SHIELD OC	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	Cathy Osborn	LTSS	1. Twenty-six nursing facilities participating (added two new facilities; deleted one facility due to facility closure) 2. Two full-time CalOptima nurses hired to monitor PIPQI. 3. Due to COVID-19 on-site visits are suspended; CalOptima nurses are doing phone outreach instead to monitor and offer support to participating facilities. Ongoing facility training - CalOptima PIPQI nurses share one PIPQI training video and discuss with each facility monthly. 4. Facilities report continued and regular use of CHG and nasal swabs. 5. Four PIPQI facilities continue to be COVID free.	Continue to Monitor. UCI launched a new infection prevention training sreies to help support the facilities during COVID and reduce the spread of the virus. Twelve facilities are participating in intensive hands on training; all facilities are able to access the training website, webinars and training materials. CalOptima PIPQI nurses will gather HAI scores, product purchase invoices and participation rates.	

Back to Agenda

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Fourth Quarter 2020 Meeting Summaries

November 3, 2020: PACE Quality Improvement Committee (PQIC) Meeting and PACE Infection Control Subcommittee Summary

- All PQIC members present
- Infection Control Subcommittee: PACE's Response to COVID-19:
    - Continued wellness calls to participants with 3,200 made in the month of September.
    - Continued offering drive-thru immunizations and COVID-19 testing; 57 participants received COVID-19 testing in quarter 3.
    - Continued reporting COVID-19 statistics to CMS and DHCS.
    - Continued providing transportation services to participants for outside specialty appointments as well as for delivery of care packages and durable medical equipment.
    - Continued contact tracing of participants contracting COVID-19 through community acquired transmission.
    - Implemented limited skilled services, such as physical and occupational therapies, deemed essential to maintain functional capacity
    - Implemented non-skilled services such as community ambulation programs and assistance with showering.
    - Implemented the new telehealth platform, VSee.
- Membership: PACE was below goal, but this was anticipated in light of the pandemic. We do expect to enroll 6–7 new participants in the months of October and November.
- Immunizations: Pneumococcal vaccination rate is 94%. We continue to advance with the influenza immunization campaign, and at the end of September, 89% of the participants were vaccinated. We will continue to provide drive-through immunizations.
- Falls without Injury: In quarter 3, we saw a downward trend in falls without injury. Trends indicated that most of the falls occur in the participant's bedroom area and are the result of a loss of balance. Members of the PACE Falls Committee are educating and providing interventions to participants to prevent future falls. We will continue to monitor any trends.
- Appeals and Grievances: No appeals were reported. Two grievances were filed that were investigated. Resolution letters were sent to the participants and the participants expressed satisfaction with the resolution. We continue to monitor.

Back to Agenda

- Medication Errors: No errors were reported.
- Quality Incidents: There were a total of four quality incidents, which include one fall, two elopements and one pressure ulcer. Root Cause Analyses are conducted for each unusual quality incident and interventions and recommendations are implemented.
- Quality Initiatives:
    - Advance Health Care Directive: At the conclusion of quarter three, 92 participants had an advance health care directive. This initiative will continue into the 4th quarter.
    - Immunizations: An immunization dashboard was presented. An emphasis has been placed on administering both the Prevnar 13 and Pneumovax 23 pneumonia vaccines. Data indicate that 73% of the participants have had both pneumococcal conjugates. Ninety percent of the participants are up to date on their tetanus vaccine, and 73% of the participants have received the shingles vaccine. We will continue to maximize immunization opportunities.

December 8, 2020: PQIC Meeting Summary

- Elizabeth Lee is absent. All other PQIC members present.
- Infection Control Subcommittee: PACE's response to COVID-19:
    - Continued providing wellness calls to participants with more than 2,700 calls made in the month of November.
    - Continued to offer drive-through immunizations and COVID-19 testing to participants; 26 participants had a COVID-19 test in the months of October and November.
    - Continued reporting of COVID-19 statistics to CMS and DHCS.
    - Continued providing limited skilled services, such as physical and occupational therapies, deemed essential to maintain functional capacity. Seventy-two participants received physical, occupational or speech therapies in November.
    - Continued providing non-skilled services such as community walks through our community ambulation program as well as assistance with showering. Twenty-nine participants were provided such services.
    - Continued implementation of the new telehealth platform, VSee, including training both providers and participants in the use of the program.
    - Continued providing transportation for participants accessing specialty care appointments.
    - Continued holding weekly PACE Leadership meetings to discuss potential actions needed in response to COVID-19.
- Improve the Quality of Care for Participants:
    - Membership: We are below our goal for quarter 3. This, however, is to be anticipated in view of the pandemic.

Back to Agenda

  - Immunizations: The pneumococcal vaccination rate at the end of quarter 3 rests at 94%. There continue to be participants who refuse the vaccine. Interventions include a one-on-one discussion with their PCP regarding the importance of this vaccine. Our influenza vaccination rate is at 90%.
  - Infection Control: A decline continues in the respiratory infection rate, and we remain below the national benchmark.
  - Physician Orders for Life-Sustaining Treatment (POLST): 95% of the participants have completed a POLST. Completing the POLST remains challenging since the participants' signature is required.
  - Functional Assessments: 100% of the participants have completed their functional assessments.
  - Comprehensive Diabetes Care:
    - Blood Pressure Control: We are above our goal at 84% for this indicator. We anticipate that this number will continue to improve as our providers, nurses and medical assistants continue to work together in monitoring participants' blood pressure.
    - Eye Exams: We are above goal with a rate of 99%, with monitoring ongoing.
    - Nephropathy Monitoring: We are at 100% and continue to monitor.
  - Medication Reconciliation Post-Discharge: 100% compliance continue to monitor.
- Ensure Safety of Clinical Care:
  - Use of Opioids at High Dosages: We have reduced the number of participants who are on higher doses of opioids to one participant. We continue monthly follow up with the participant.
  - Drug Disease Interactions in the Elderly:
    - Rate of Drug Disease Interaction for participants with dementia: We have met our goal and are at 29% (goal is less than 35.7%).
    - Rate of Drug Disease Interaction for participants with chronic kidney disease: We have met our goal at 2.7% (goal is less than 3.9%).
  - Day Center Falls: No day center falls were reported since it is closed. However, we continue to monitor falls in the home.
- Ensure Appropriate Use of Resources:
  - Access to Specialty Care: We are at goal at 96% and continue to monitor.
  - Hospital/ER/Readmissions Utilization:
    - Thirty-day Readmission: We met goal and continue to monitor.
    - Acute Hospital Stays: Yearly and quarterly rates were presented. For quarter 3, we noted an increase in the rates, mostly a result of COVID-19 hospitalizations.

Back to Agenda

    - Emergency Room Utilization: We met goal in this area. Participants continue to be resistant to going to the ER due to the COVID-19 outbreak. Instead, more participants are using the urgent care after-hours service. Wellness calls continue to all participants at least once a week to ensure they are not delaying urgently needed care.
- Long-Term Care: 2% of the participants are in long-term care. We continue to closely monitor participants who transitioned from custodial care to home care due to the COVID-19 health crisis.

Back to Agenda

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Member Trend Report: 3rd Quarter 2020

Board of Directors' Special Quality Assurance Committee Meeting
February 25, 2021

Ana Aranda, Director, Grievance and Appeals Resolution Services

Back to Agenda

Overview

- Complaints by category
- Appeals and Grievance trends
  - Per 1,000 member months for Medi-Cal program
  - Per 1,000 members for OneCare and OneCare Connect programs
- Interventions based on trends

Back to Agenda

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Definitions

- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service
- Grievance: An oral or written expression indicating dissatisfaction with any aspect of a CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

Back to Agenda

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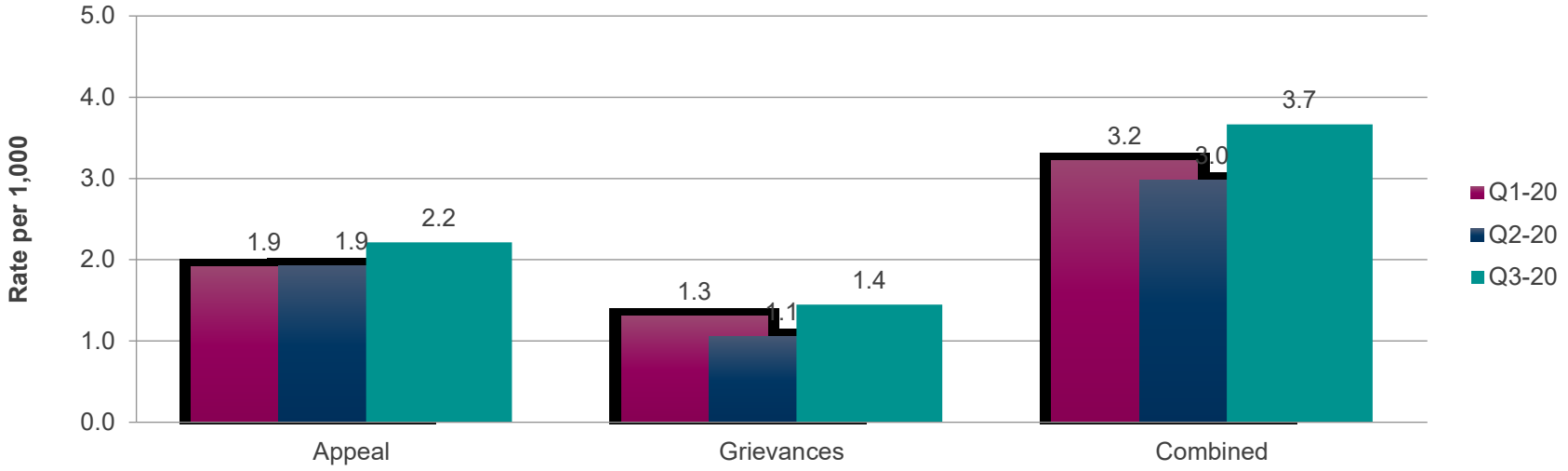
Medi-Cal Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	3,090	334	2,756	701,662
Q2-2020	2,653	348	2,305	725,939
Q3-2020	3,724	424	3,300	759,192

Back to Agenda

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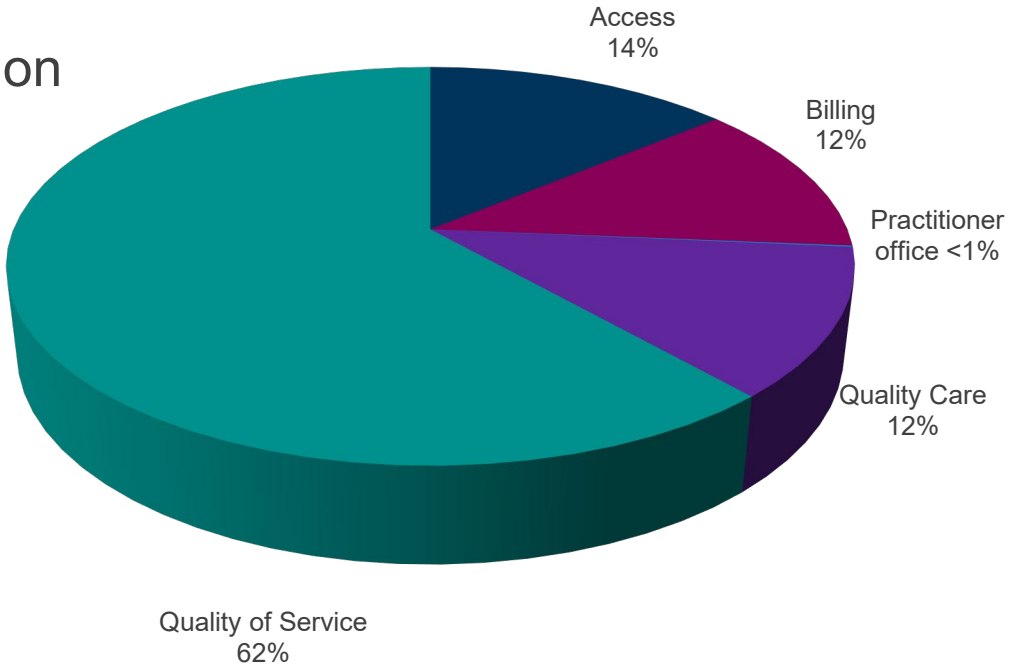
Medi-Cal Grievances by Category

- Top grievance types
  - Delays in service
  - Question treatment
  - Member billing
  - Non-medical transportation
  - Primary Care Provider
  - Provider Services



Back to Agenda

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Medi-Cal Summary

- Grievances increased by 43% from Q2 2020 to Q3 2020.
  - Access grievances increased by 66%.
  - Billing grievances increased by 41%.
  - Quality of care grievances increased by 84%.
  - Quality of service grievances increased by 34%.
- Non-medical transportation grievances increased by 73% from Q2 2020 to Q3 2020.
  - Utilization of rides increased by 13%

Back to Agenda

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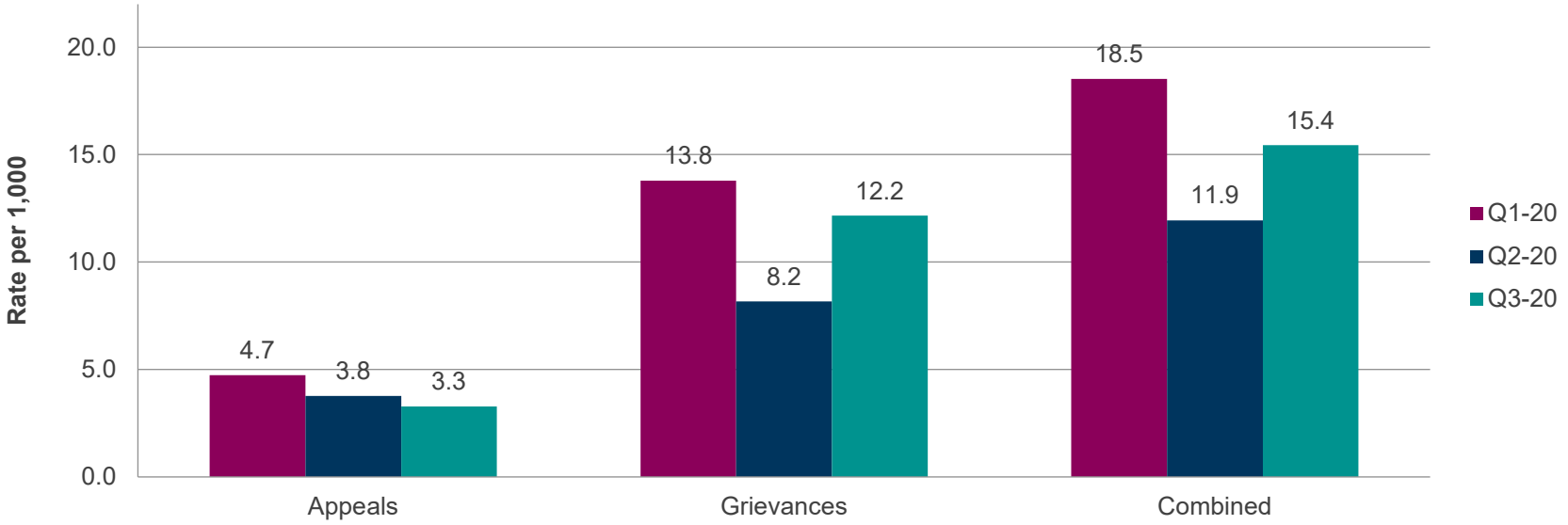
OneCare Connect Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	262	67	195	14,148
Q2-2020	171	54	117	14,318
Q3-2020	226	48	178	14,642

Back to Agenda

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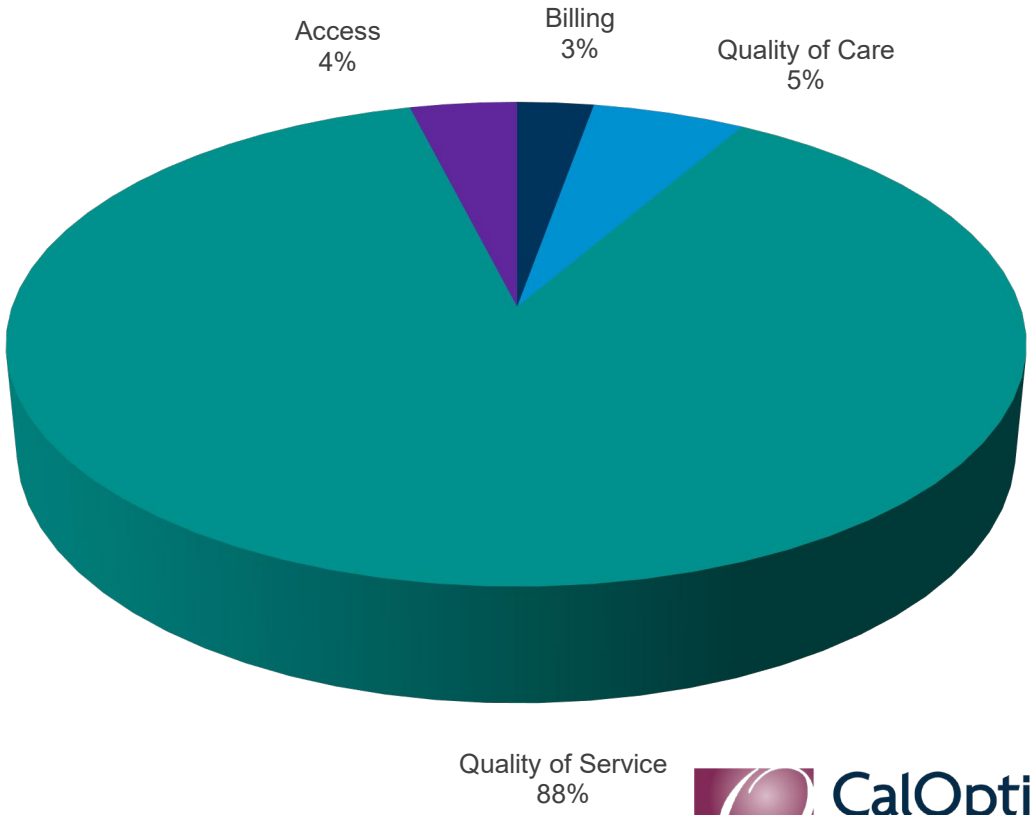
OneCare Connect Grievances by Category

- Top grievance types
  - Non-medical transportation (NMT) services
  - Primary care provider
  - Provider services



Back to Agenda

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OneCare Connect Summary

- Grievances increased by 52% from Q2 2020 to Q3 2020.
  - Increases were in all categories.
- Behavioral health grievances continue to decrease since the beginning of 2020

Back to Agenda

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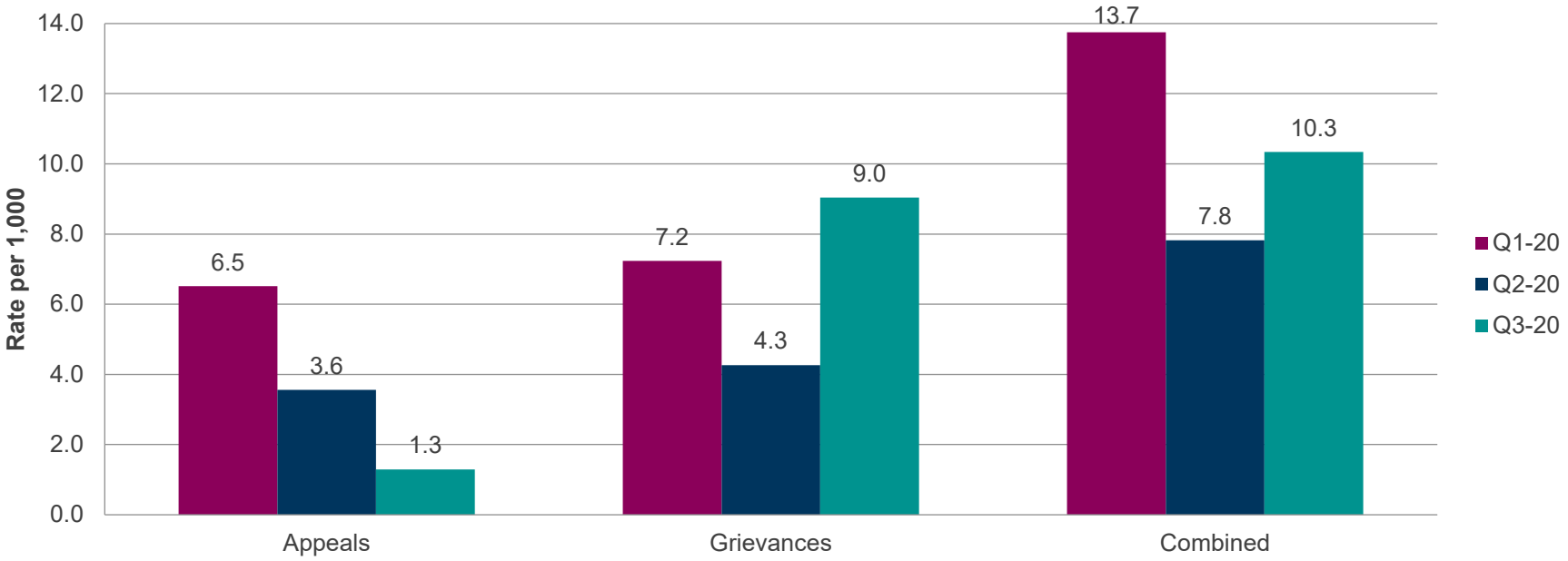
OneCare Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	19	9	10	1,382
Q2-2020	11	5	6	1,406
Q3-2020	16	2	14	1,548

Back to Agenda

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OneCare Summary

- Grievances increased from Q2 to Q3 2020, but remain relatively low
- Grievances were for the following:
  - ✓ CalOptima staff/services
  - ✓ Provider services/demeanor

Back to Agenda

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

Back to Agenda

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