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

WEDNESDAY, JUNE 14, 2023
3:00 P.M.

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Trieu Tran, M.D., Chair
José Mayorga, M.D.
Nancy Shivers, RN

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	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 materials are available for review at CalOptima Health, 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 Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_zyJ3B1QcRQarY906oHwjFw and Join the Meeting.
Webinar ID: **816 9366 0445**
Passcode: **091437** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

MANAGEMENT REPORTS
1. Chief Medical Officer Report

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.

CONSENT CALENDAR
2. Approve Minutes of the March 15, 2023 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

REPORTS/DISCUSSION ITEMS
3. Recommend that the Board of Directors Approve the 2022 CalOptima Health Utilization Management Program Evaluation and the 2023 CalOptima Health Integrated Utilization Management/Case Management Program Description

4. Recommend Board of Directors Appointments of Whole-Child Model Family Advisory Committee Members

INFORMATION ITEMS
5. Update on Assessment of Quality

6. National Committee for Quality Assurance (NCQA) Health Plan Accreditation Update

7. HEDIS® MY2022 Preliminary Results

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

9. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Health Equity Committee Report
   b. Program of All-Inclusive Care for the Elderly Report
   c. Member Trend Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Regular Quality Assurance Committee on June 14, 2023 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_zyJ3B1QcRQarY906oHwjFw

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/81693660445?pwd=UC94MVRVNmhjYkRUYlM1bjRpYWFndz09

Passcode: **091437**

Or One tap mobile:
+16694449171,,81693660445#,,,,*091437# US
+12532050468,,81693660445#,,,,*091437# US

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

Webinar ID: **816 9366 0445**
Passcode: 091437
International numbers available: **https://us06web.zoom.us/u/kjCnriDod**

MEMORANDUM

DATE:	June 8, 2023
TO:	CalOptima Health Quality Assurance Committee
FROM:	Richard Pitts, D.O., Ph.D., Chief Medical Officer
SUBJECT:	CMO Report — June 14, 2023, Board of Directors Quality Assurance Committee
COPY:	Sharon Dwiers, Clerk of the Board

a. <u>Skilled Nursing Facilities Team Update</u>

- SNF action team formed.
- Added Dr. Steven Arabo, our new medical director with expertise in Medicare/Medi-Cal and SNFs.
- Reviewed barriers to moving members/patients from acute care to skilled nursing homes to recuperative care.
- Held kick-off meeting on June 6 with UCI, Illumination Foundation and our CalOptima Health SNF team.
    - During this meeting more key barriers were identified and appear to be "easily" solved.

- Major action items:
    - Set up an escalation pathway.
    - Establish a weekly review of cases meeting if needed — added to our weekly care/review meeting.
    - Create a "Playbook" for how to make direct referrals to Illumination Foundation.
- Many residents rotate through the emergency department which often results in admission to the hospital.
- Create an easy-to-read working "flow chart" identifying "stop and go" checkpoints.
- This is a high-level summary; the key is to open lines of communication.

b. Cancer Screening Program Update:

- CalOptima Health's Population Health Management (PHM) department is leading the Comprehensive Community Cancer Screening and Support Program approved by the Board in December 2022. Lead physicians are Dr. Richard Lopez and Dr. Shilpa Jindani.
- As part of the program, PHM is working to partner with a variety of stakeholders including (but not limited to): The Orange County Cancer Coalition, UCI Chao Family Comprehensive Cancer Center, Vietnamese American Cancer Foundation, American Cancer Society, Susan G. Komen Foundation, and the Coalition of Orange County Community Health Centers.
- One of the first strategies to emerge is a Mammography pilot program in collaboration with City of Hope Lennar Foundation Cancer Center in Irvine.
- The mammography pilot with City of Hope launched on May 1, 2023.
- Efforts to launch the mammography pilot have included:
    - Weekly meetings with City of Hope to develop pilot.
    - Data analysis to identify CCN members, ages 50 to 74 who are due for a mammogram and live within a 15-mile radius of City of Hope in Irvine.
    - CalOptima Health Medical Directors Dr. Jindani and Dr. Lopez will outreach to the Primary Care Providers of the identified CCN members to share information on the pilot and ensure coordination of care for members participating in the pilot.
    - PHM Health Education staff will be calling the members to invite them to participate in the pilot and connect them to the City of Hope for scheduling.
    - Members who agree to participate will be contacted by the City of Hope to schedule the mammogram appointment.
    - PHM Health Education Staff will arrange transportation or other care coordination needs for the members as needed.
    - Member information will be tracked in CalOptima Health care management system (Guiding Care) to evaluate progress and track outcomes.
    - Staff have developed a detailed workflow in collaboration with City of Hope to ensure the member experience is seamless and provides members with high-quality comprehensive care from end to end.
    - Future items on the breast cancer screening roadmap include developing similar pilot programs with FQHCs that have on-site mammography services and exploring partnerships with mobile mammography providers.

- According to a 6/3/23 Wall Street Journal article, **"**Few Get Lifesaving Lung Cancer Test":
    - Only 6% of people deemed eligible for lung cancer screening test choose to have it done.
    - The 5-year survival rate when lung cancer is caught early is about 60%, compared with around 7% if caught after the disease has spread.
    - "It's low-hanging fruit for the country. It would save the most lives immediately."
    - Some eligible people said they didn't know the test existed and assumed a lung cancer diagnosis was a death sentence.

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 15, 2023

A Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee was held on March 15, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023.

Chair Trieu Tran, called the meeting to order at 3:00 p.m., and Director Mayorga led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.; Nancy Shivers, R.N.
(All Committee Members participated in person, except Director Shivers, who participated remotely under "Just Cause" using her first of two uses for the Quality Assurance Committee)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, M.D., Chief Medical Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director; Quality Improvement; Donna Frisch, M.D., Medical Director, PACE; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

Chair Tran reordered the agenda to hear Management Reports ahead of the Information Items.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

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

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

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REPORTS/DISCUSSION ITEMS

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

Donna Frisch, M.D., Medical Director, PACE Program, introduced the item, starting with major accomplishments from the 2022 PACE Quality Improvement Plan Evaluation. Some of the accomplishments included: swift response to updates regarding the COVID-19 pandemic; continued use of telehealth modalities; 95% of eligible PACE participants received at least one COVID-19 booster vaccine; 93% of participants received their annual influenza vaccine; 88% of participants received their Pneumococcal vaccine series; and 100% of participants had their medications reconciled within 15 days of hospital discharge.

Areas for improvement include transportation and medical care. Dr. Frisch noted there was a lot of turn-over of providers in medical care and transportation continues to be a challenge.

Dr. Frisch reviewed the proposed 2023 PACE Quality Improvement Plan, which included the following: reducing repeat falls and fall prevention, increasing the number of PACE participants that have completed an advanced health care directive with a goal of over 50%; increasing participant satisfaction with contracted dental services with a goal of less than one dental-related grievance per quarter; and increasing participant satisfaction with transportation services with a goal of less than three transportation-related grievances per quarter.

Action: ***On motion of Director Mayorga, seconded and carried, the Committee recommended that the Board of Directors: Receive and file the 2022 CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement (QI) Plan Evaluation, and Approve the 2023 PACE QI Plan. (Motion carried 3-0-0)***

4. Receive and File 2022 CalOptima Health Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan

Linda Lee, Executive Director, Quality Improvement, introduced the item, starting with achievements in 2022. Some of the achievements/public recognition included: in September 2022 received 4 out of 5 in the National Committee for Quality Assurance (NCQA's) Medicaid Health Plan rating, and in October 2022 Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 Orange County Visionaries in a special publication of the LA Times OC. Some of CalOptima Health's accomplishments in 2022 include: establishing a health equity workgroup, which collected stakeholder feedback to determine what framework components should be included and what should be focused on. Ms. Lee noted that one of the first areas CalOptima Health focused on was cross functional training for internal and external stakeholders for social determinants of health data collection. Another goal was achievement of a high star rating for Medicaid. CalOptima Health also implemented two CalAIM programs, Enhanced Care Management and Community Supports, and initiated a Homeless Health program. Ms. Lee noted that CalOptima Health met 13 of the 15 Medi-Cal Accountability Set measures that the Department of Health Care Services (DHCS) measures on an annual basis.

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Ms. Lee also reviewed opportunities for improvement, which included falling below the minimum performance level of the 50th percentile for two measures, well-child visits from birth to 15 months and well-child visits from 15 to 30 months. She noted that CalOptima Health has implemented corrective action and is actively working on improving these measures. Ms. Lee also noted that low member satisfaction is the main driver of low performance indicated by CalOptima's OneCare stars rating. She noted that the areas identified as opportunities for improvement will be the focus of the 2023 Quality Improvement Work Plan. Ms. Lee added that CalOptima Health did not meet the goal of 80% in members to providers ratio and members getting appointments within established timeframes, so this is another focus area for 2023.

Ms. Lee reviewed the proposed 2023 Quality Improvement Work Plan, noting that it has been reorganized into four main categories: quality of care, safety, member experience, and quality of service. She added that CalOptima Health has established three overarching goals for 2023: to implement a comprehensive health equity framework; to improve quality of care and member experience to obtain NCQA 5-star rating and 4 stars for Medicare; and to implement pay for value programs that touch all CalOptima Health's provider partners.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors: Receive and File the 2022 CalOptima Health Quality Improvement Program Evaluation, and Recommended Board of Directors Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan. (Motion carried 3-0-0)***

5. Recommend Board of Directors Approval of Revision to the Measurement Set for the CalOptima Health's Measurement Year 2023 Medi-Cal Quality Pay for Value Program

Ms. Lee introduced the item, noting that this is a change from what was recommended at the December 2022 Board meeting. She added that since December 2022, DHCS has revised the proposed accountability set that it is holding health plans accountable to, which is what CalOptima Health's pay for value program is based on. Ms. Lee clarified that this item is being brought before the Committee so that CalOptima Health is in alignment with DHCS's measurement set.

Director Mayorga asked if certain measures are weighed more heavily. Yunkyung Kim, Chief Operating Officer, responded that yes there is a weighting, but it is not based on CalOptima Health's performance. It is based on the type of metric.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: Recommend Board of Directors Approval of Modification of the Measurement Set for the 2023 Health Network Medi-Cal Pay for Value Performance Program for the Measurement Period Effective January 1, 2023, through December 31, 2023. (Motion carried 3-0-0)***

6. Recommend Board of Directors Approval of New CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

Ms. Lee introduced the item, noting that this is a new policy that CalOptima Health is implementing to ensure that Medi-Cal members ages 45 and older receive a comprehensive annual wellness visit

from their primary care physician and the program is inclusive of incentives to both members and providers. Members can receive $50 gift card for completion and providers receive $125 for providing the annual wellness visit and can receive an additional $100 if they fully document all of the components of a well care visit.

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: Recommend Board of Directors Approval of new CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program. (Motion carried 2-0-0; Director Mayorga recused)***

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reviewed his Chief Medical Officer Report with the Committee. Regarding Ms. Lee's comment and his name being mentioned as an OC visionary, Dr. Pitts noted that he would say that the recognition includes all of the staff. Nothing gets done without CalOptima Health staff.

Dr. Pitts noted that his report is in the Quality Assurance Committee meeting materials, but he wanted to highlight the five-year comprehensive community cancer screening program. He noted that it is a very important initiative and will help all of the other efforts by the American Cancer Society, University of California, Irvine, and others to raise awareness and reduce late stage cancers and save lives.

INFORMATION ITEMS

7. Update on Assessment of Quality

Ms. Lee introduced the item, noting that this assessment of quality reflects her findings over the last few months of being the new Executive Director of Quality Improvement. She added that she launched a comprehensive review of CalOptima Health's quality infrastructure policies, processes, and programs and looked at current strengths, risks, and opportunities for improvement. Ms. Lee noted an area of strength that she identified is Healthcare Effectiveness Data and Information Set (HEDIS) report and audit processes. This process is very mature. Ms. Lee noted that CalOptima Health went through its HEDIS audit this week and finished in record time because the auditors had very little to ask and CalOptima Health was fully compliant with requirements.

Ms. Lee reviewed some areas of risk, which included decreased performance for OneCare star ratings. CalOptima Health's rating is trending down and is projected to continue to trend down. Last year CalOptima Health was at 4 stars, this year it is at 3 stars, and next year it is projected to be at 2.5 stars. As previously reported, CalOptima Health is below the state's minimum performance level for well care visits, which is a requirement by DHCS. CalOptima Health is also at risk in the area of access and availability. Ms. Lee reviewed several additional areas for improvement and noted that staff has put into place focused initiatives to improve upon risk areas and will be monitoring all areas closely and will report back regularly to this Committee and the full Board on the status of these interventions.

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8. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
Ms. Macias provided an update on the recent activities of the PACE Member Advisory Committee.

The following items were accepted as presented.

9. 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
The Committee members thanked staff for the work that went into preparing for the meeting. Chair Tran thanked Marsha Choo and Monica Macias for their reports.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 4:15 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 14, 2023

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 14, 2023
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

3. Recommend that the Board of Directors Approve the 2022 CalOptima Health Utilization Management Program Evaluation and the 2023 CalOptima Health Integrated Utilization Management/Case Management Program Description

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Utilization Management, (657) 900-1013

Recommended Actions

- Recommend Board of Directors' approval of the 2022 CalOptima Health Utilization Management Program Evaluation, and
- Recommend Board of Directors' approval of the 2023 CalOptima Health Integrated Utilization Management and Case Management Program Description.

Background

CalOptima Health's Utilization Management (UM) Program describes how medically necessary and quality health care services are delivered to 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.

CalOptima Health's UM Program is reviewed and evaluated annually and approved 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 Health's achievements in 2022 included:

- Resolved the Q4 2021-Q1 2022 treatment authorization backlog issue and ensured interventions and protocols are in place to mitigate further occurrences;
- Improved workflows to prioritize aging inventory to exceed regulatory turnaround time compliance;
- Expanded Medical Directors' responsibilities and capacities;
- Enhanced the behavioral health role in the development and oversight of the UM Program; and
- Implemented the 90 Day Emergency Department (ED) Pilot Program to determine if focused clinical support in real time within the ED setting would impact members accessing post ED care.

In 2022, the CalOptima Health UM leadership worked with the analytics team to develop real time reporting capabilities and implemented internal structural changes to improve the timeliness and

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operational effectiveness of the UM Program. Additional improvements included the addition of Medical Director leaders, a dedicated clinical trainer, and filling several key roles that were vacant in 2021. Process improvements such as improved workflows, standardized templates and improved real time reporting all contributed to UM Program enhancements during 2022.

Discussion

CalOptima Health staff has newly developed the 2023 Integrated UM and Case Management (CM) Program Description to include quality, pharmacy, Population Health Management (PHM), and behavioral health initiatives and care delivery. This will ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business and aligned with health network and strategic organizational changes.

The revisions are summarized as follows:

- Comprehensive Health Equity framework to further enhance and improve quality of care and member experience;
- Clinical Pharmacy updates;
- PHM Program framework;
- UM Program Goals;
- CalAIM Goals;
- CM Program Goals;
- Utilization Management Committee Updates;
- Behavioral Health highlights; and
- CBAS updates.

The purpose of the 2023 Integrated UM and CM Program Description is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

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

Fiscal Impact

The recommended action to approve the 2023 CalOptima Health Integrated UM and CM Program Description does not have a fiscal impact beyond what was incorporated in the Fiscal Year 2023-24 Operating Budget and separate Board actions.

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Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2022 UM Program Evaluation
2. 2023 UM/CM Integrated Program Description (Redline version)
3. 2023 UM/CM Integrated Program Description (Clean version)
4. Annual Review: 2022 UM Program Evaluation and 2023 UM/CM Integrated Program Description (PowerPoint)

/s/ Michael Hunn *06/08/2023*

Authorized Signature **Date**

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2022 CalOptima Health
Utilization Management
Program Evaluation

A. EXECUTIVE SUMMARY

The 2022 Utilization Management (UM) Program description defines and outlines CalOptima Health's activities to provide optimal utilization and quality health care services that are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM program structure, scope, processes, and information sources used to determine utilization trends, medical necessity, and benefit coverage determinations. This evaluation of UM activity is reviewed and approved annually by the UM Committee (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC). The look back period for the 2022 UM program evaluation is Q4'2021 through the end of Q3'2022.

Program Structure and Process

The UM program was enhanced throughout 2022 to ensure member needs were addressed, while maintaining compliance with regulatory and accreditation standards. Although the staffing model for the UM department working prior authorization requests and conducting inpatient reviews did not change during the 2022 reporting period, CalOptima implemented multiple process improvement throughout the year to address operational and clinical enhancements. These included but not limited to the following:

- Improved workflows to prioritize aging inventory to exceed regulatory turnaround time compliance
- UM clinical team standardized templates for medical director reviews
- Inpatient facility clinical rounds to conduct peer to peer and complex discharge planning and support
- Improved access to real time reporting and tools to address authorization requests
- Enhanced provider portal automation and capabilities
- Addition of a dedicated clinical trainer
- Temporary coverage for all vacant roles to minimize the impact of staffing fluctuations

Program Structure

During 2022, CalOptima added three additional medical directors to the UM Program to continue to address clinical complexities and the need for additional specialty programs and interventions.
The following specialties and medical directors with robust experience in key areas were

added to the full-time medical director team within the UM Program:

- Internal and Preventative Medicine with Case Management and Gender Affirming Care experience and expertise
- Family Practice with extensive experience with Population Health Management experience
- Surgery and Transplant with experience in performing complex cancer procedures

The Deputy Chief Medical Officer and the PACE Medical Director vacated in 2021 were filled during 2022. A dedicated clinical trainer role was added and a process to secure clinical and non-clinical temporary staffing coverage for any open positions was established. Information sources as well as staff assigned activities used to determine benefit coverage and medical necessity remained current and appropriate. Medical Necessity coverage tools and hierarchical protocols are reviewed and approved annually at the UMC.

Program Scope Impact

Effective January 1, 2022, DCHS mandated MediCal retail pharmacy and pharmacy grievances be carved out of managed care health plans and on January 1, 2022, Magellan Rx began managing the pharmacy benefit for CalOptima. CalOptima assisted in the transition by resolving access issues around outpatient pharmacy and educating the members on the variances with the formulary and access continuity of treatment. In addition,

B. PROJECTS, PROGRAMS AND INITIATIVES

A. Utilization Management

Oversight of prior authorization (PA) inventory continued to be part of the overall UM program to improve average time to decision aligned with CalOptima Health's strategic vision for same day treatment authorizations. Interventions put into place to address a backlog of cases identified during Q4 2021 continue to ensure regulatory and accreditation requirements remain compliant, and members receive timely decisions on requested services. The UM Medical Director(s) remained very engaged in the UM process and provided continuing clinical oversight for the administration of the UM Program. This oversight and support included but is not limited to reviewing outcomes in UMC to ensure compliance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluating the program's effectiveness against established goals.

UM Medical Directors

The UM Medical Directors (including Behavioral Health and Pharmacy) are responsible for overseeing provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). The purpose of this committee is to evaluate new and modified benefits and determine the need for prior authorization. This committee is led by the chair Medical Director and includes input from peer Medical Directors, Deputy Chief Medical Officer, and Clinical Leaders within Utilization management. This activity continues to gain provider and member satisfaction by allowing the provider network to inform decisions on what requires prior authorization and allow for access and automation where appropriate.

The assigned UM Medical Director responsible for facilitating the bi-weekly Utilization

Management Work Group (UMWG) ensures collective CalOptima Clinical leadership, Medical Director leaders, including behavioral health, pharmacy and Deputy Chief Medical Officer all provide input to the development and processes of the UM Program to ensure that quality care is delivered to CalOptima Health members to meet their physical health, behavioral health and social drivers of health needs. The Medical Director team conducted semiweekly case rounds with the nursing team and ad hoc meetings with hospitals and health networks to provide guidance in managing complex cases in post-acute and ambulatory settings as appropriate. The Medical Director team also provided to the CalOptima clinical team and external provider education and consultation on specific topics including, but not limited to:

- Genetic testing
- Gender Affirming Care and Procedures
- Management of administrative days
- Appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria
- Letter of Agreement (LOA) process
- and Evaluation and Medical Director oversight of the appropriateness of one-day inpatient stays.

The assigned Behavioral Health Medical Director and the Behavioral Health Integration (BHI) clinical leadership team provided oversight and input on the UM program throughout the year to ensure that all BH activities are integrated and aligned with the medical program to ensure compliance with UM regulatory and accreditation requirements and to ensure parity in decision-making. The designated BH Medical Director and BH clinical leadership participated in biweekly UM work groups and quarterly, Utilization Management Committee (UMC) and Benefit Management Subcommittee (BMSC) meetings to ensure adequate representation of critical BH topics such as expansion of the autism benefit and development of strategies to address substance use disorder, eating disorders and coordination with the county to serve our shared members during this period.

During Q3 2022, a 90-day Emergency Department (ED) Diversion pilot was implemented to determine if focused clinical support of CalOptima in real time within the ED setting would impact members accessing post ED care. The primary measurements of success established for the pilot were:

- Increase CalAIM authorized community support.
- Increase PCP follow up visits within 30 days of the ED visit.
- Decrease unnecessary ED utilization by redirecting to a more appropriate setting.

The pilot included a CalOptima embedded LVN within the ED to provide real-time prior authorizations post stabilization to appropriate alternate levels of care and/or outpatient services including coordination and scheduling services and referrals to case management.

- Early outcomes analysis determined that 72% of the members initially identified as high utilizers of ED services were successfully connected with ambulatory care and CalAIm Enhanced Care Management (ECM) services after pilot interventions.
- A total of 190 members were seen as a part of the pilot program for the following

successful interventions in real time:

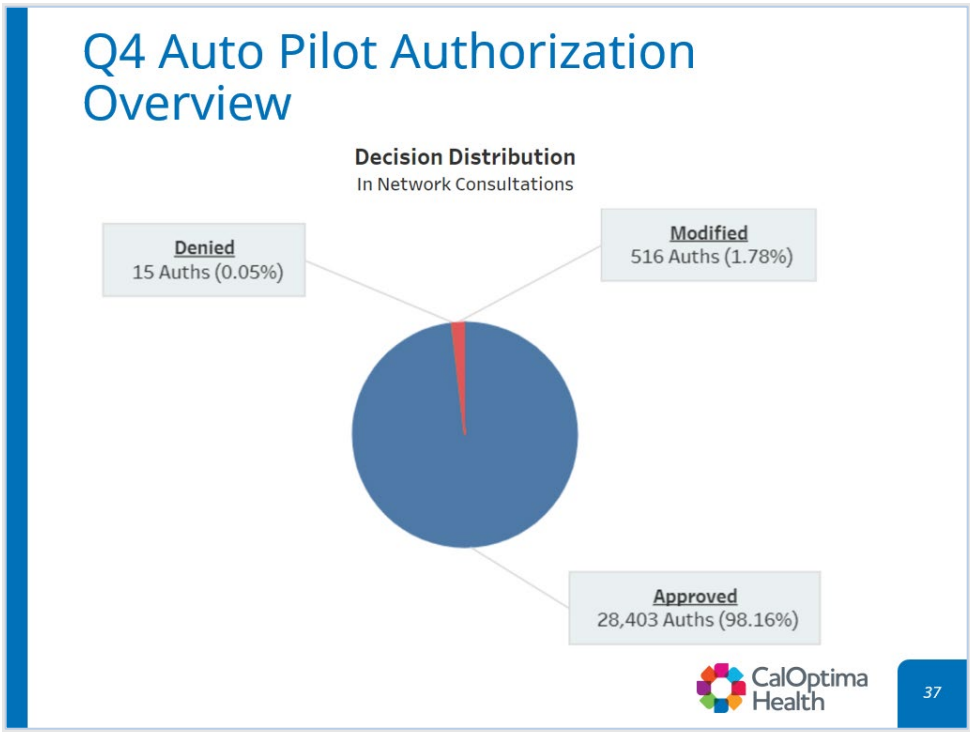
- PCP Appointments scheduled 16%
- Specialty Appointments scheduled 11%
- Other Case Management Referrals 4%
- Prior Auth Referrals completed 9%
    - Transportation issues resolved 3%
    - Medication Issues resolved 8%
    - Community Support Referrals 13%

Next Steps:

- Additional pilot analysis including claims review
- Consideration of automation for specific and targeted services based on analysis and MD review.
- Continue program through real time remote communication (Teams channel, telephonic secure email)
- Identify future opportunities programmatic and remote support to leverage economies of scale

Auto-Authorization Pilot

During Q2 2022 an auto-authorization pilot project was implemented for the CCN and COD to assess auto-authorization trends for in-network consultations. Each quarter UM leadership and Medical Directors reviewed utilization patterns during pilot automation. Below is the Q3 data for utilization oversight reported to UMC in Q4.



Q4'22 Auto-Authorization (pilot) – *Top Referring Specialty*

CCN/COD only

Quarter 4		
Auto Approved Referring Specality (pilot)	*Count*	*%*
Family Medicine	9873	30.6%
Internal Medicine	3871	12.0%
Nurse Practitioner	3110	9.6%
Clinic (mixed specialty)	1998	6.2%
Physician Assistant	1655	5.1%
Group (mixed specialty)	1084	3.4%
Ophthalmology	1075	3.3%
CalAIM Community Supports	1063	3.3%
General Practice	997	3.1%
Certified Family NP	893	2.8%
Hematology/Oncology	891	2.76%
Orthopaedic Surgery	606	1.88%
Endocrinology/DiabetesMellitus	589	1.83%
Grand Total: 32,229		

CalOptima Health

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Q4'22 Auto-Authorization (pilot) – *Top Refer-To Provider*

CCN/COD only

Quarter 4		
Auto Approved Refer-to-Provider (pilot)	*Count*	*%*
Acuity Eye Group	794	2.5%
Sun Terra Produce Traders Inc	626	1.9%
Ivy-Joan E Madu	563	1.7%
OC Gastrocare	543	1.7%
Island Dermatology	541	1.7%
George H Garcia	532	1.7%
Martin J Backman	522	1.6%
Philip L Bucur	436	1.4%
Quoc A Nguyen	419	1.3%
Pacific Cardiovascular Associates	382	1.2%
Haresh S Jhangiani	381	1.18%
Christopher C Ninh	379	1.18%
Essam R Quraishi	368	1.14%
Grand Total: 32,229		

CalOptima Health

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B. Behavioral Health Integration

CalOptima Health manages all the administrative functions of Medi-Cal, OneCare (OC) and OneCare Connect (OCC) mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima Health members. The BHI department continues to

be 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.

C. UM Data Management

The UM data reporting design is led by the director of UM and generated by CalOptima Health's Enterprise Analytics (EA) and Information Technology Services (ITS) department staff. Together with UM department subject matter experts, EA and ITS maintained a focused effort to improve the visibility and understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima Health and the delegated health networks (HNs). Further refinement of daily inventory reports continued throughout 2022 to ensure continued timely processing of treatment authorization requests. Additional efforts are being planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by developing standard queries in the CalOptima Health data mart.

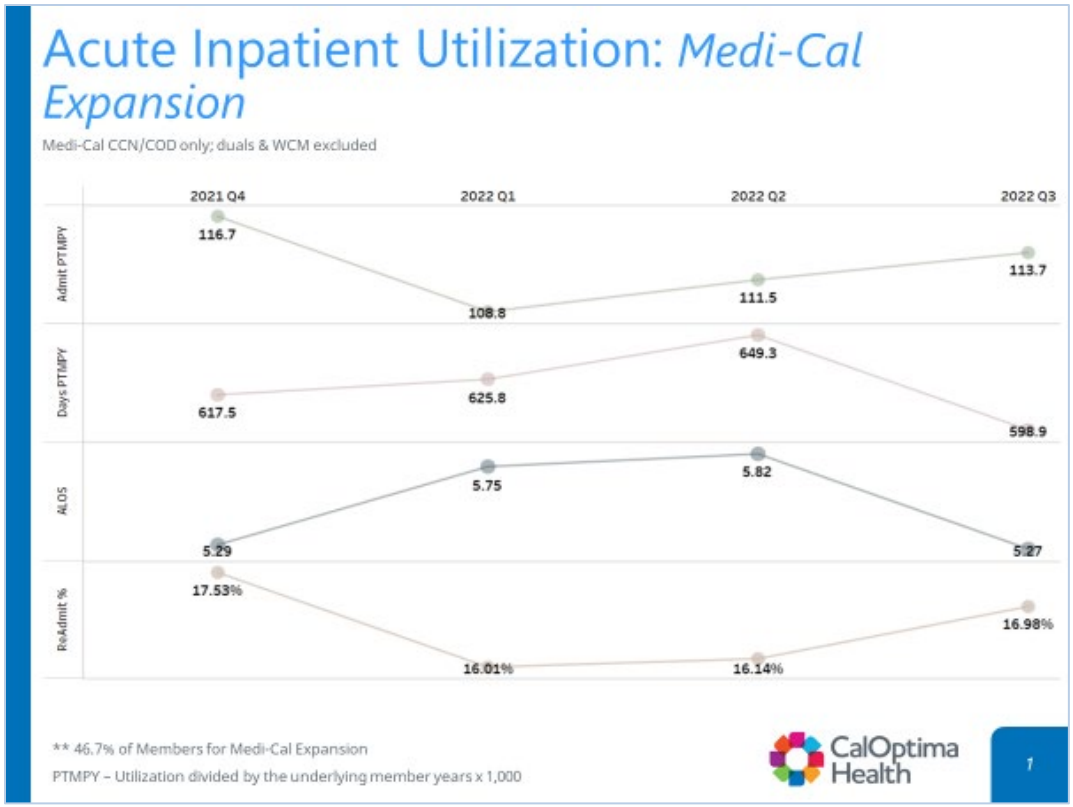
Inpatient and Emergency Department (ED) Utilization Performance

A. 2022 Performance Goals – MCD roll up (excludes WCM and HN data)

Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	5.09	5.30	5.31	4.82
Admit PTMPY	284	120.4	114.2	116.6	126.0
Days PTMPY	358	613.1	605.4	619.5	607.1
Readmit %	25%	16.73%	15.96%	15.26%	16.79%

The goals for 2022 were set for a rollup of all MediCal Aid categories. During a 2022 UMC the request was to split out and report on each MediCal Aid category therefore there is an expediated variance in the goal based on MediCal Aid category.

B. MediCal Expansion



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	5.29 ↑	5.75 ↑	5.82 ↑	5.27 ↑
Admit PTMPY	284	116.7 ↓	108.8 ↓	111.5 ↓	113.7 ↓
Days PTMPY	358	617.5 ↑	625.8 ↑	649.3 ↑	598.8 ↑
ReAdmit %	25%	17.53% ↓	16.01% ↓	16.14% ↓	16.98% ↓

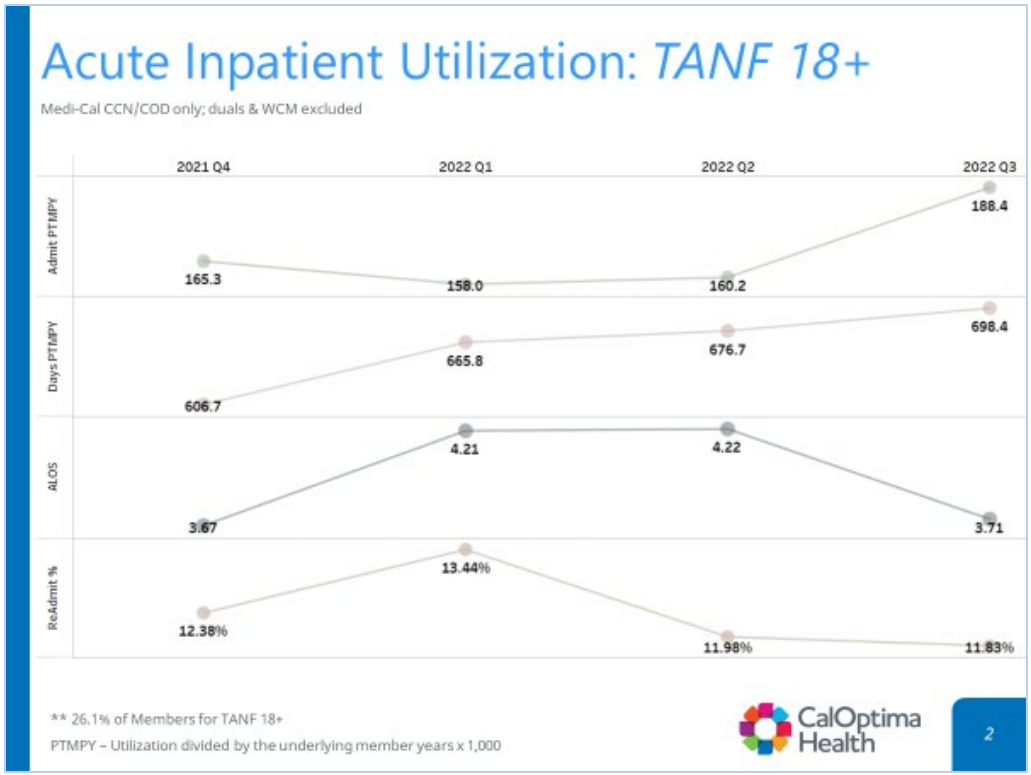
Average Length of Stay (ALOS): The ALOS for this population remained above the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a slight decline during Q3.

Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and an upward trend during Q2 and Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained above the goal of 358 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a downward trend during Q3.

Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period declining in 2022 Q1 and Q2 with an upward trend in Q3.

TANF +18



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	3.67 ↓	4.21 ↓	4.22 ↓	3.71 ↓
Admit PTMPY	284	165.3 ↓	158.0 ↓	160.2 ↓	188.4 ↓
Days PTMPY	358	606.7 ↑	665.8 ↑	676.7 ↑	698.4 ↑
ReAdmit %	25%	12.38% ↓	13.44% ↓	11.98% ↓	11.83% ↓

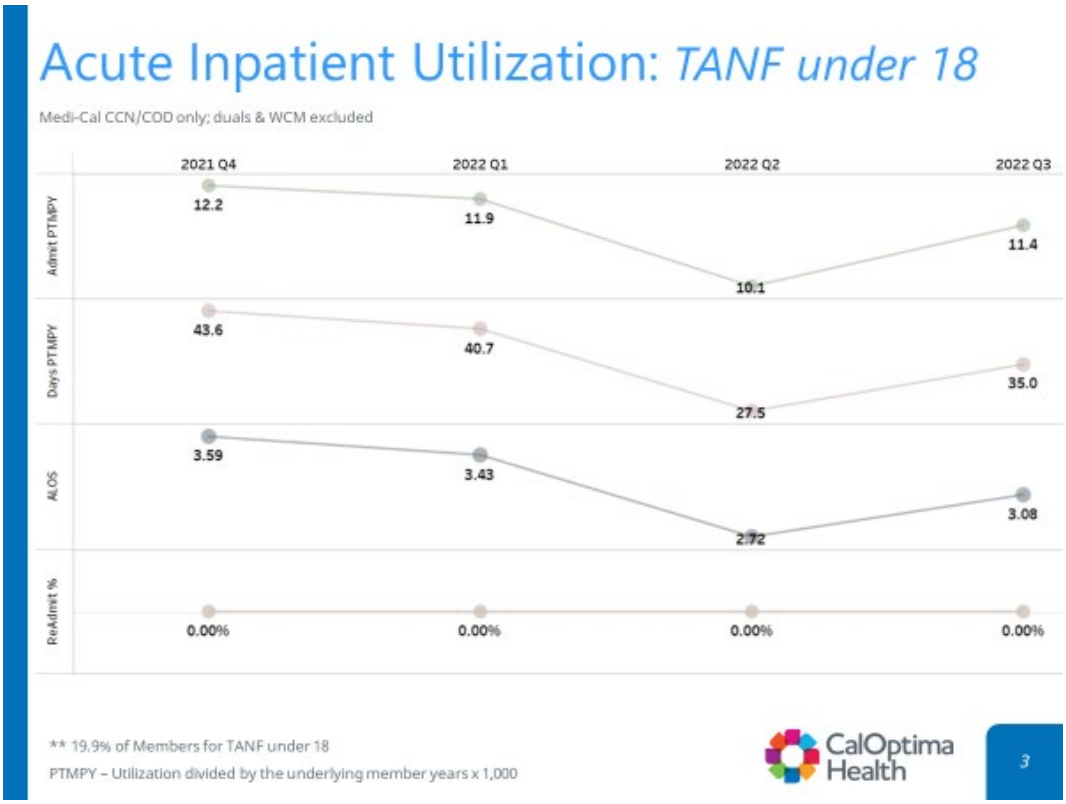
Average Length of Stay (ALOS): The ALOS for this population remained below the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a slight decline during Q3.

Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained above the goal of 358 throughout the 2022 reporting period with an upward trend throughout 2022 Q1 – Q3.

Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period with a slight increase in 2022 Q1 and a downward trend during Q2 and Q3.

TANF <18



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	3.59 ↓	3.43 ↓	2.72 ↓	3.08 ↓
Admit PTMPY	284	12.2 ↓	11.9 ↓	10.1 ↓	11.4 ↓
Days PTMPY	358	43.6 ↓	40.7 ↓	27.5 ↓	35.0 ↓
ReAdmit %	25%	0.00%	0.00%	0.00%	0.00%

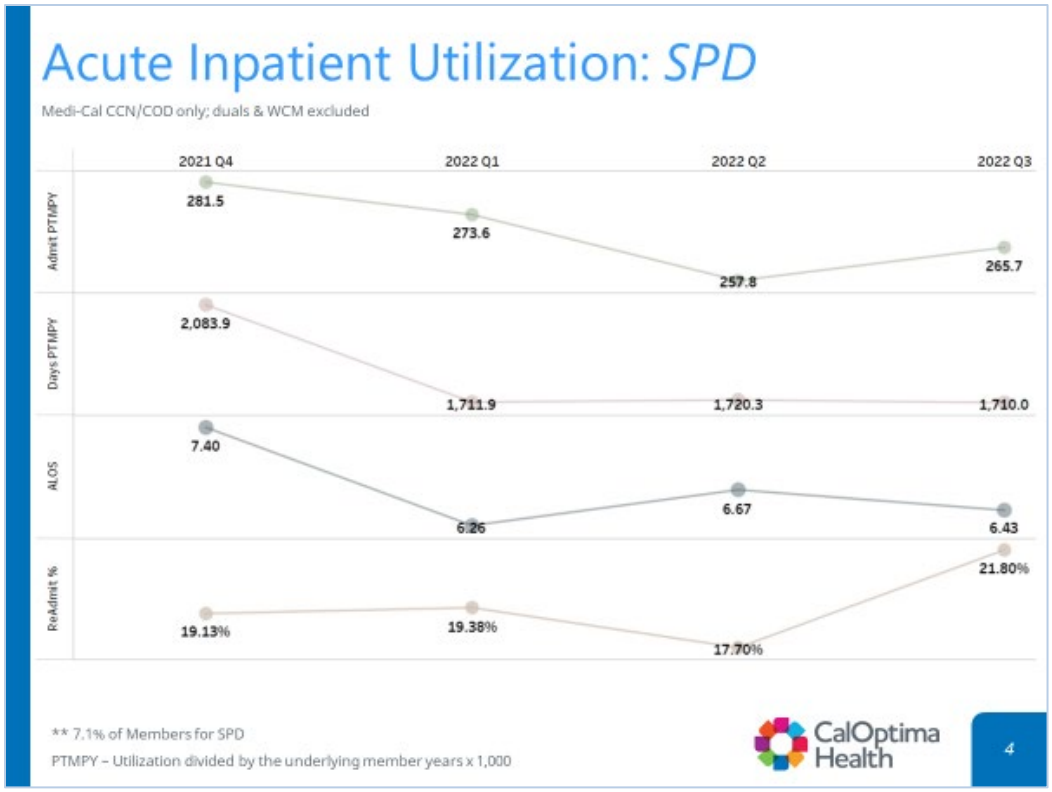
Average Length of Stay (ALOS): The ALOS remained below the goal throughout the 2022 reporting period.

Admits/1000 per Year (PTPMY): The Admits/1000 remained below the goal throughout the 2022 reporting period.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/1000 remained below the goal throughout the reporting period.

Readmissions: Data regarding readmits was unavailable for this population during the 2022 reporting period.

SPD



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	7.40 ↑	6.26 ↑	6.67 ↑	6.43 ↑
Admit PTMPY	284	281.5 ↓	273.6 ↓	257.8 ↓	265.7 ↓
Days PTMPY	358	2,083.9 ↑	1,711.9 ↑	1,720.3 ↑	1,710.0 ↑
ReAdmit %	25%	19.13% ↓	19.38% ↓	17.70% ↓	21.80% ↓

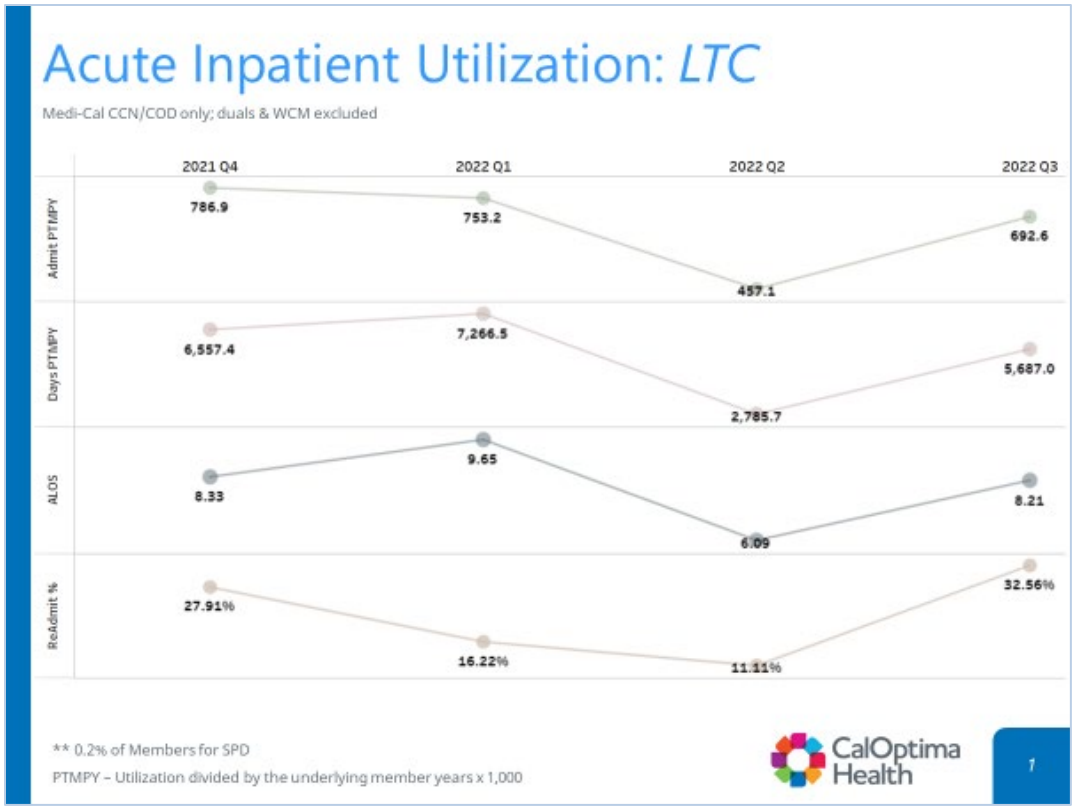
Average Length of Stay (ALOS): The ALOS for this population remained above the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q2 and a slight decline during Q3.

Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained significantly above the goal of 358 throughout the 2022 reporting period, however, a downward trend was noted during 2022 Q1 – Q3.

Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period with a decrease during 2022 Q2 and an uptick during Q3.

Long Term Care (LTC)



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	8.33 ↑	9.65 ↑	6.09 ↑	8.21 ↑
Admit PTMPY	284	786.9 ↑	753.2 ↑	457.1 ↑	692.6 ↑
Days PTMPY	358	6,557.40 ↑	7,266.50 ↑	2,785.70 ↑	5,687.00 ↑
ReAdmit %	25%	27.91% ↑	16.22% ↓	11.11% ↓	32.56% ↑

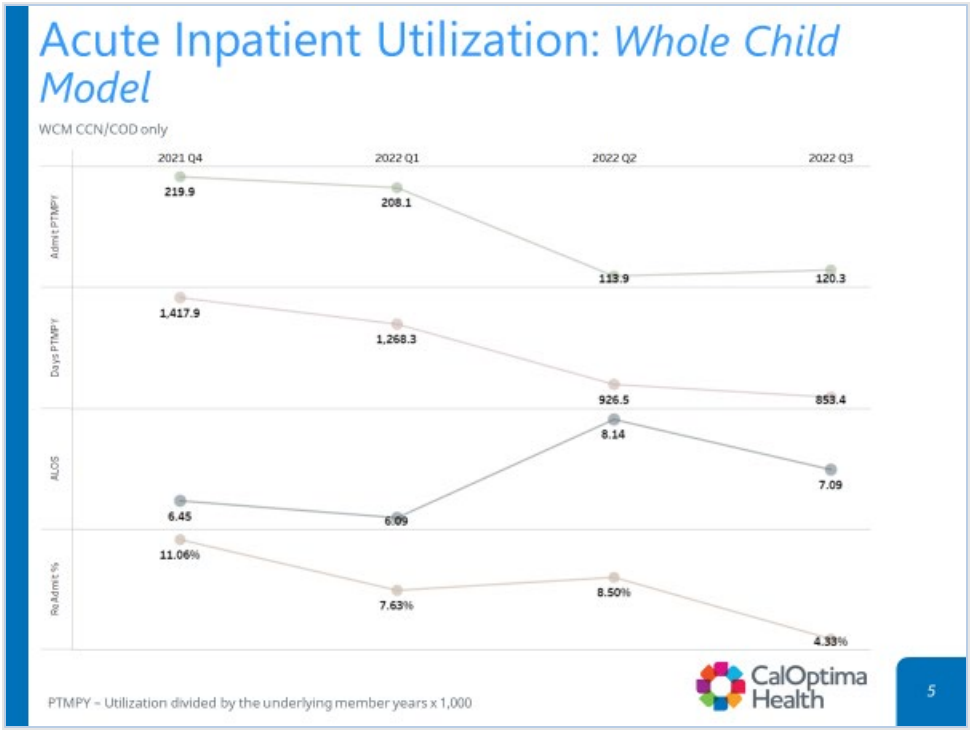
Average Length of Stay (ALOS): The ALOS remained above the goal throughout the 2022 reporting period.

Admits/1000 per Year (PTPMY): The Admits/1000 remained above the goal throughout the 2022 reporting period with a notable decrease in 2022 Q2.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/1000 remained above the goal throughout the 2022 reporting period with a notable decrease in 2022 Q2.

Readmissions: Readmits remained below goal during 2022 Q1 and Q2.

Whole Child Model



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	6.45 ↑	6.09 ↑	8.14 ↑	7.09 ↑
Admit PTMPY	284	219.9 ↓	208.1 ↓	113.9 ↓	120.3 ↓
Days PTMPY	358	1,417.9 ↑	1,268.3 ↑	926.5 ↑	853.4 ↑
ReAdmit%	25%	11.06% ↓	7.63% ↓	8.50% ↓	4.33% ↓

Average Length of Stay (ALOS): The ALOS for this population remained above the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q2 and a slight decline during Q3.

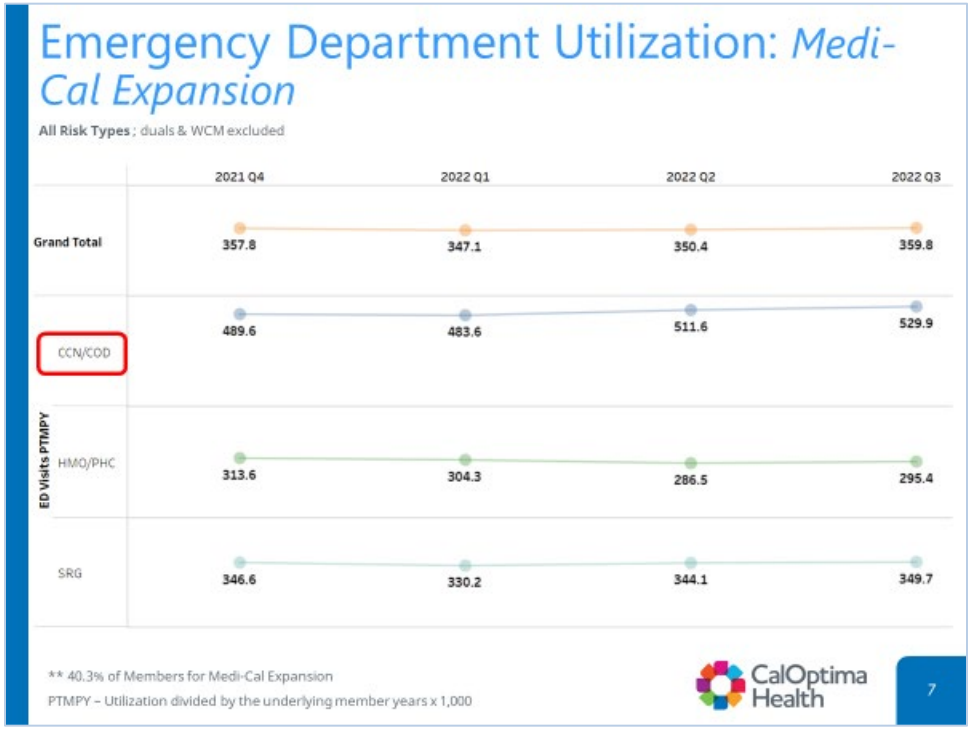
Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained significantly above the goal of 358 throughout the 2022 reporting period, however, a downward trend was noted during 2022 Q2 – Q3.

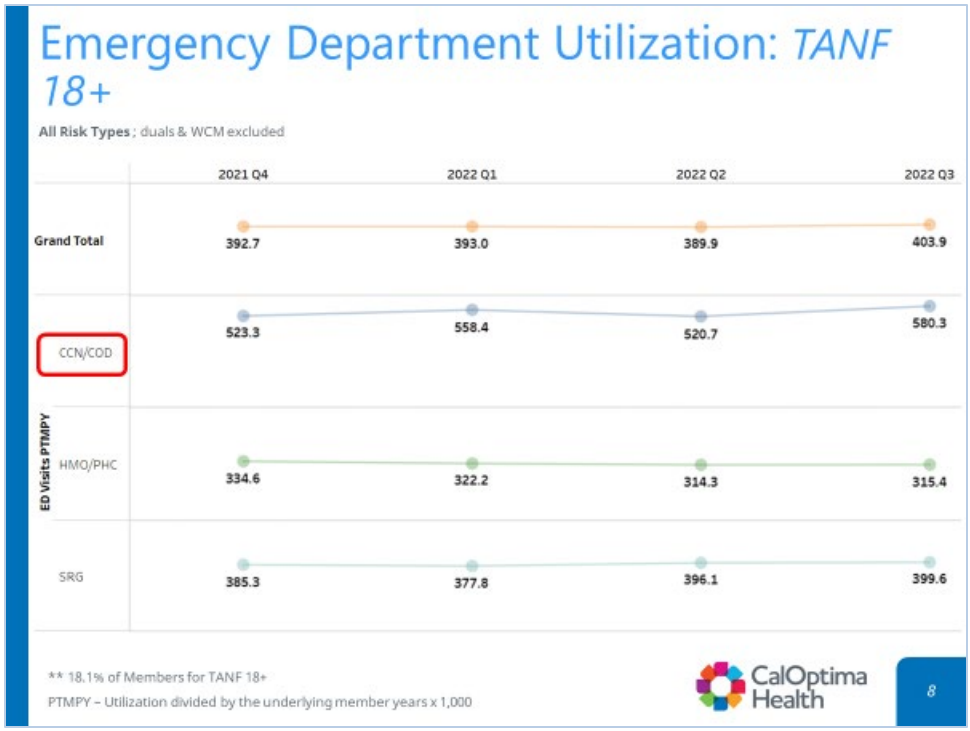
Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period with a decrease during 2022 Q3

Emergency Department Utilization by Aid Code line of business

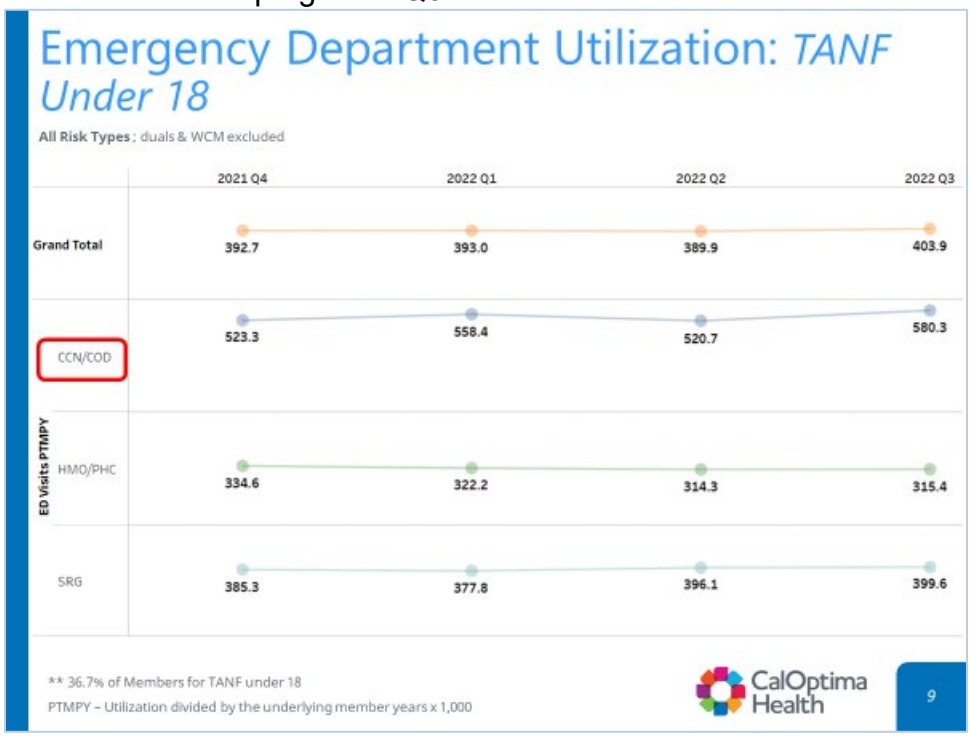
Line of Business	2021 Q4	2022 Q1	2022 Q2	2022 Q3
MediCal Expansion	489.6	483.6	511.6	529.9
TANF 18+	523.3	558.4	520.7	580.3
TANF <18	355.7	342.9	368.8	375.1.
SPD	772.6	700.1	688.0	748.3
LTC	480.9	487.4	385.7	386.2
WCM	519.7	491.2	278.1	293.2



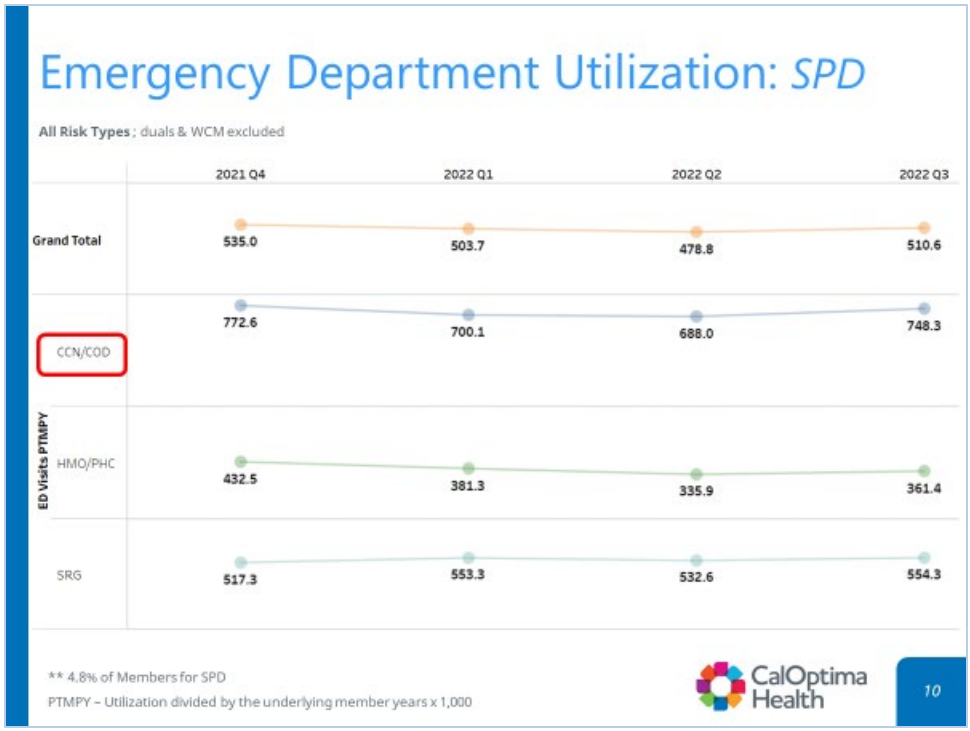
- **MediCal Expansion:** ED utilization declined in 2022 Q1 from 2021 Q4 and then trended upward 2022 Q2 and Q3.



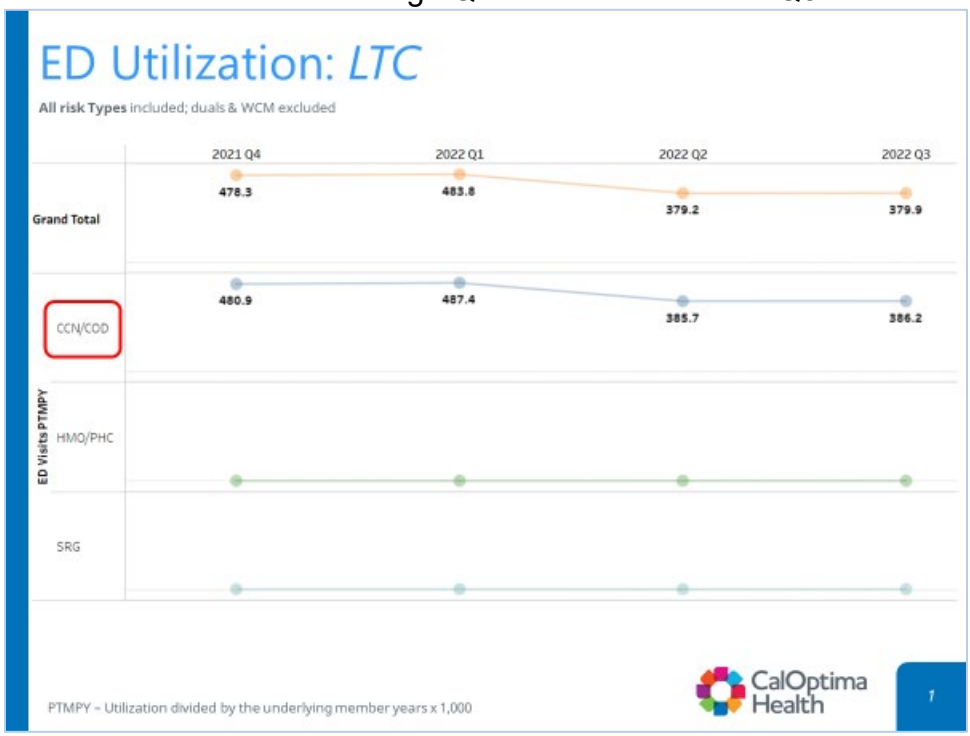
- **TANF 18+**: ED utilization increased during 2022 Q1 from 2021 Q4, trended down in Q2 and back up again in Q3.



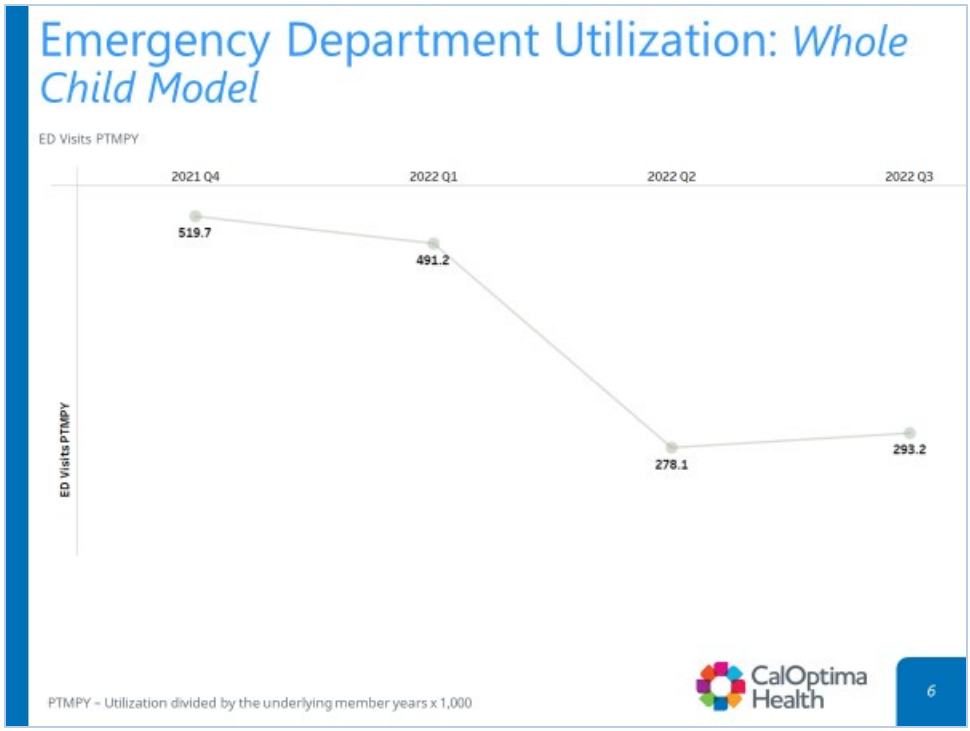
- **TANF <18**: ED utilization decreased during 2022 Q1 from 2021 Q4 then trended up during Q2 and Q3.



- **SPD**: ED utilization decreased during 2022 Q1 from 2021 Q4 and continued the downward trend through Q2 with an increase in Q3.



- **LTC**: ED utilization increased slightly during 2022 Q1 from 2021 Q4 then trended downward during Q2 and Q3.



WCM: ED utilization decreased during 2022 Q1 from 2021 Q4 and continued with a significant downward trend during Q2 and Q3.

Whole – Child Model (WCM)

Whole-Child Model (WCM) Membership

CalOptima Health

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WCM Member Counts

Health Network	Reporting Period	# of total WCM Eligible Members as of 1st day of Reporting Period	# of total newly eligible WCM members as of 1st day of Reporting Period	# of aged out WCM members
506-Cal Optima-Orange	**December 2022**	**11,524**	**185**	**1,492**
CalOptima Community Network	December 2022	1,047	65	207
Kaiser Permanente	December 2022	924	22	125
HPN - Regal	December 2022	24	1	4
Optum Care Network – Monarch	December 2022	863	18	108
Prospect Medical Group, Inc.	December 2022	169	2	39
Family Choice Health Network	December 2022	239	2	49
CHOC Health Alliance	December 2022	6,810	50	680
AMVI Care Health Network	December 2022	162	2	25
Noble Mid-Orange County	December 2022	166	4	25
Optum Care Network – Talbert	December 2022	116	2	33
Optum Care Network – Arta	December 2022	325	5	77
AltaMed Health Services	December 2022	364	4	78
United Care Medical Group	December 2022	315	8	42

CalOptima Health

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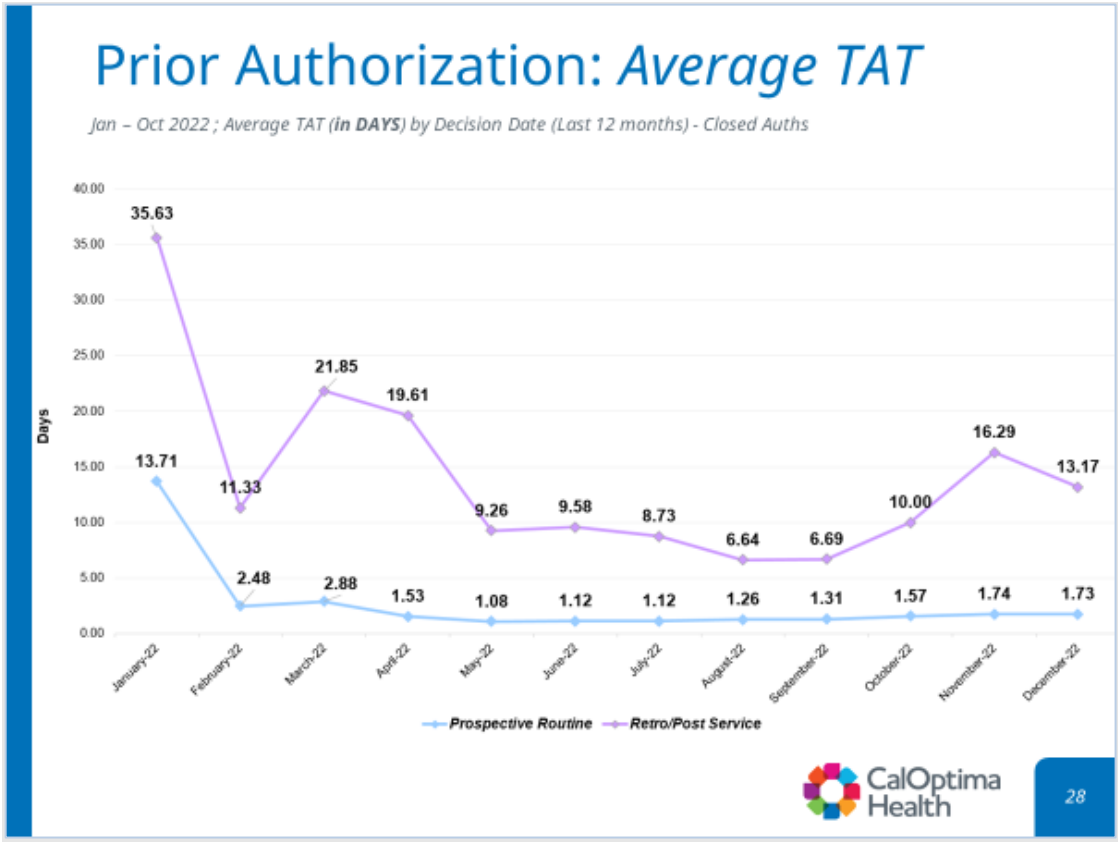
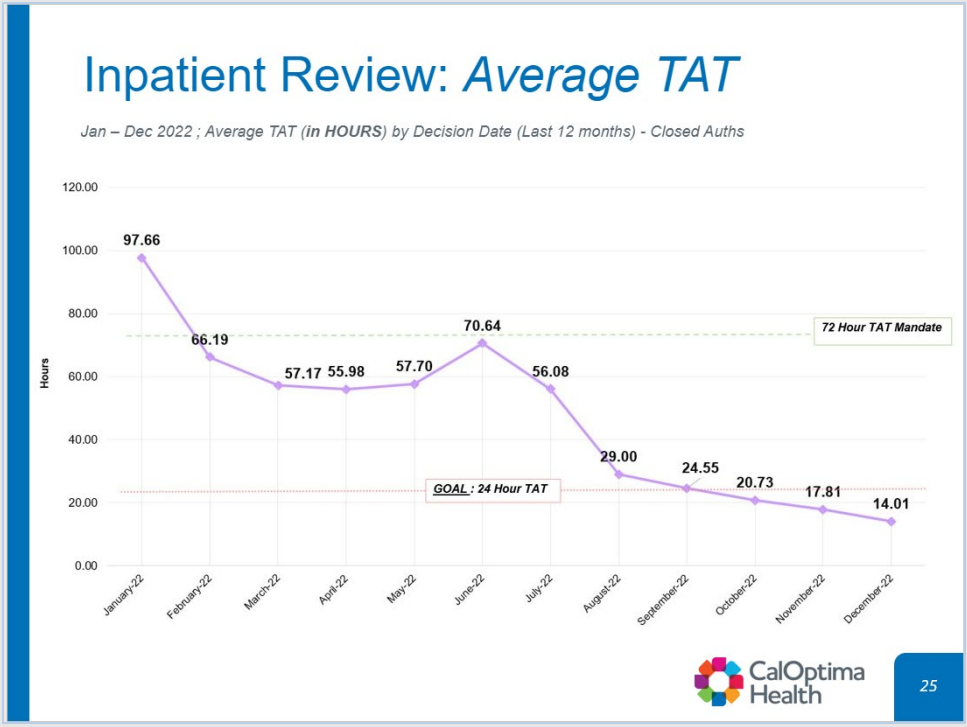


Prior Authorization Turnaround Time Compliance (TAT) Q4 2021 - Q3 2022					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2021	**Qtr4**	Medi-Cal	65.18%	87.31%	70.55%
		OneCare	60.00%	50.00%	100.00%
		OneCare Connect	94.41%	90.32%	86.36%
2022	**Qtr1**	Medi-Cal	90.15%	99.10%	63.60%
		OneCare	87.50%	100.00%	-
		OneCare Connect	99.43%	98.44%	90.65%
	Qtr2	Medi-Cal	99.96%	99.74%	100.00%
		OneCare	100.00%	100.00%	-
		OneCare Connect	99.94%	100.00%	99.24%
	Qtr3	Medi-Cal	99.99%	99.95%	100.00%
		OneCare	100.00%	100.00%	100.00%
		OneCare Connect	100.00%	100.00%	100.00%

Q4 2021 TAT compliance reflects the ongoing resolution of the backlog that was identified in Q3 2021.The backlog was resolved 01/27/2022. The results of these efforts are evident with compliance in all areas at the beginning of 2022 Q2.

Inpatient Review Authorization Average time to decision - January 2022 thru December 2022



Inpatient Turn Around Compliance

Inpatient Turn Around Compliance (TAT) Q4 2021 - Q3 2022				
Year	Quarter	LOB	Urgent Inpatient	Retrospective Inpatient
2021	Qtr4	Medi-Cal	62.35%	69.10%
2022	Qtr1	Medi-Cal	68.34%	77.38%
		OneCare	0.00%	100.00%
		OneCare Connect	66.47%	76.92%
	Qtr2	Medi-Cal	71.79%	73.49%
		OneCare	100.00%	100.00%
		OneCare Connect	78.42%	83.33%
	Qtr3	Medi-Cal	89.79%	78.07%
		OneCare	50.00%	-

		OneCare Connect	93.72%	80.00%

Referrals Processed Q4 2021 - Q3 2022					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2021	**Qtr4**	Medi-Cal	37,414	6,256	421
		OneCare	5	2	2
		OneCare Connect	1,878	341	154
2022	**Qtr1**	Medi-Cal	44,678	5,857	684
		OneCare	8	4	-
		OneCare Connect	1,936	320	107
	Qtr2	Medi-Cal	47,626	7,682	1,180
		OneCare	9	2	-
		OneCare Connect	1,543	304	131
	Qtr3	Medi-Cal	42,298	8,359	611
		OneCare	11	2	2
		OneCare Connect	2,146	346	121
Grand Total			179,552	29,475	3,413

Referrals Received Q4 2021 - Q3 2022	
Faxes	251,346
COLAS	198,728
• COLAS Auto Approved	75,136
Total	450,074

C. Over and Underutilization

During 2022 we continued to enhance the identification and process for monitoring over and underutilization as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization. Metrics are identified throughout the organization as good indicators of over and underutilization, as well as drilling 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 integrated utilization metrics include (physical/behavioral health and Rx) 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 2022 and reported to UMC, QIC and the Quality Assurance Committee (QAC).

D. Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests — Medical

Summary of referral volume (Q4 2021 to Q3 2022)

Referrals Processed		Referrals Received		Turnaround Time Compliance (TAT)	
Routine	**177,262**	Faxed	**251,346**	Routine TAT	**90.87%**
+-Urgent	**27,931**	COLAS	**198,728**	Urgent TAT	**96.95%**
Retro	**2,734**	Auto Auth	**93,341**	Retro TAT	**89.94%**
Total	**207,927***	**Total**	**543,415**		

VI. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance for CY22:

LOB	TAT Compliance
OC	99.89%
OCC	99.92%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans.

Pharmacy metric targets were achieved for 2022.

VII. 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 2021:
  - CBAS CEDT: 99.90%
  - CBAS Routine: 99.80%
  - CBAS Expedited: None received
    - Members participating in CBAS Q4 2020 & Q1–Q3 2021: Potentially program-eligible members.

Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)					
Year	**Quarter**	**LOB**	**Members Participating in CBAS Q4 2019-Q3 2021 / Potentially Program-Eligible Members**	**% Participating**	**Change from Previous Qtr.**
2021	**Q4**	Medi-Cal	2,657/99,910	2.65	↑
		OCC	151/19,965	1.01	↓
2022	**Q1**	Medi-Cal	2,738/120,535	2.27%	↑
		OCC	151/14,591	1.03%	↑
	Q2	Medi-Cal	2780/122,953	2.26%	↓
		OCC	167/14,288	1.17%	↑
	Q3	Medi-Cal	2,871/126,808	2.26%	NC
		OCC	173/14,667	1.18%	↑

- 80% of authorized CBAS participation days will be utilized/delivered Q4 2021

CBAS Participation Days Used / Days Authorized				
Year	**Qtr.**	**CBAS Participation Days Used / Days Authorized**	**% Used**	**Change from Previous Qtr.**
2021	**Q4**	117,601/104,003	88.43%	↑
2022	**Q1**	171,621/131,161	76.42%	↓
	Q2	166,668/154,217	92.5%	↑

	Q3	182,267/140,056	76.84%	↓

* Change in tableau reporting will true-up in future data

- LTC routine turnaround time goal is >95%. Goal met.
  - Q4 2021: 98.19%
  - Q1 2022: 97.45%
  - Q2 2022: 95.69%
  - Q3: 2022: 98.65%
  - Q4: 2022: 96.76%
- LTC Urgent: None received

MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

MSSP Admissions / Discharges			
Year	**Qtr.**	**Admissions/ Discharges**	**Change from Previous Qtr.**
2021	**Q4**	18/ 21	Admissions ↓
2022	**Q1**	29/ 21	Admissions ↑
	Q2	32/ 25	Admissions ↑
	Q3	41/ 39	Admissions **NC**

MSSP Goal not met in Q4 2021 due to the PHE. Continue with this goal.

E. Utilization Performance / Outcomes

A. LTC and CBAS Transition

Analysis of inpatient and ED data in 2021 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of 2021 ED Data will be conducted, and additional interventions may be applied as needed.
LTC Nursing facility members transitioned to the Community:

LTC Nursing Facility Members Transition to the Community					
Year	Qtr.	LOB	LTC Nursing Facility Members Transitioned	% Transitioned	Change from Previous Qtr.

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			otheCommunity		
[illegible]	Q 4	Medi-Cal	126/4,751	2.65%	↓
		C C C	7/175	2.65%	↓
[illegible]	Q 1	Medi-Cal	141/4,628	3.05%	↑
		C C C	5/165	3.03%	↑

Q2	Medi-Cal	194/4,869	3.98%	↑
	OCC	7/164	3.98%	↑
Q3	Medi-Cal	200/4,868	4.11%	↑
	OCC	4/161	7.14%	↑

CBAS: Track CBAS participants who transition to LTC.

CBAS participants who transition to LTC					
Year	**Qtr.**	**LOB**	**CBAS participants who transition to LTC**	**% Transitioned**	**Change from Previous Qtr.**
2021	Q4	Medi-Cal	4/2,657	0.15%	↓
		OCC	0/1	0.00%	↓
2022	Q1	Medi-Cal	8/2,738	0.29%	↓
		OCC	1/151	0.66%	↑
	Q2	Medi-Cal	8/2,780	0.29%	↑
		OCC	0/167	0.00%	←
	Q3	Medi-Cal	9/2,780	0.31%	↑
		OCC	1/173	0.58%	←

LTC: Members residing in LTC: Potentially nursing home eligible members.

Members Residing in LTC/ Potentially Nursing Home Eligible Members					
Year	Qtr	LOB	Members Residing in LTC/ Potentially Nursing H	% Residing in LTC	Change from Prev. Qtr.

			oneEligibleMembers		
2021	**Q4**	Medi-Cal	4,751/99,910	4.76%	↑
		COC	175/14,965	1.17%	↓
2022	**Q1**	Medi-Ca	4,628/1	3.84%	↓

		I	20,535		
		CCC	165/14,591	1.13%	↓
	Q2	Medi-Cal	4,869/122,593	3.96%	↓
		CCC	164/14,288	1.15%	↑
	Q3	Medi-Ca	4,468/	3.84%	↓

		I	126,808		
		CCC	182/14,667	1.24%	↑

B. Pharmacy Utilization

- Retail Pharmacy: $PMPM costs for CY22 are below expected spend for OneCare and above expected spend for OneCare Connect. OneCare Connect drug cost increases are primarily driven by increased utilization of brand diabetes and chemotherapy medications.
- Goals were met for two of the three adherence measures. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

Pharmacy Utilization			
Measure	**Medication Adherence for Diabetes Medications**	**Medication Adherence for Hypertension (RAS antagonists)**	**Medication Adherence for Cholesterol (Statins)**
Rate	87%	89%	88%
Goal	88%	89%	88%

F. **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 2022. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	96%
UM Clinical Staff: Concurrent Review	96%
Physicians	99%
Pharmacy	94%
LTSS: LTC	97%
LTSS: CBAS	97%
LTSS: MSSP	97%
Behavioral Health	98%

C. Member and Provider Satisfaction

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, including the CAHPS survey, related to the UM Program. Complaints about the UM Program demonstrated some trends in the following categories:

- Member feedback obtained through Grievances and Appeals:
  - Access to providers, specifically providers no longer contracted with CalOptima health.
  - 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.

- Member Feedback from 2022 CAHPS survey:
  - Only 71.3% of adult members and 73.0% of child members usually or always got an

appointment with a specialist as soon as needed, with a decrease from 81.4% from the previous survey for adult members.
    - Only 80.8% of child members felt it was usually or always easy to get the care, tests, or treatment child needed, with a decrease from 85.6% from the previous survey.

- Provider feedback from CalOptima Provider Satisfaction survey 2022:
    - 55% of providers reported being satisfied or very satisfied with the UM Program experience, with further examples citing
        - Rapid response to questions
        - Access to direct referrals
        - Timely processing of treatment requests
    - 10% of providers reported being somewhat dissatisfied or very dissatisfied with the UM Program Experience, with examples citing.
        - Challenges with the Authorization Dept processing retro-authorization requests for Private Duty Nursing
        - Denial policy is not in guide with standards of care

Potential Quality Issues (PQIs) are reviewed by the CalOptima Health Medical Directors and trend data related to authorization issues is reported quarterly at the Utilization Management Committee. In 2022, there were a total of 27 PQIs related to related to the UM Program:

Potential Quality Issues (PQIs)					
	Q1	**Q2**	**Q3**	**Q4**	**TOTAL**
Authorization Denied or Delayed	0	5	9	13	27

CalOptima is continually looking at improving response times to treatment authorizations including proactive peer to peer consultations and communication to expediate health plans decisions.

G. SUMMARY

In January 2022, UM resolved the backlog of UM of treatment authorization requests that were identified in Q4 2021. The resolution was reflected in the Q2 2022 turnaround time data. The CalOptima UM leadership team worked with the analytics team to develop real-time reporting capabilities and implemented internal structural changes to improve the timeliness and operational effectiveness of the UM program.
Additional improvements included the addition of medical director leaders, dedicated clinical trainer, and filling several key roles that were vacant in 2021. Process improvements such as improved workflows, standardized templates and improved real time reporting all contributed to UM Program enhancements during 2022. CalOptima enhanced monitoring protocols internally to align and oversee direct network and delegated Health Networks. Major initiatives included improvements to CalOptima's operational process and improvements to leadership oversight to address treatment authorizations fluctuating inventory and staffing needs. Continuous improvement took place during 2022 based on monitoring, auditing and outcomes.

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, QIC and Medical Director team including behavioral health leadership continued to guide and support process improvement, review and address utilization trends and continues to enhance the CalOptima program through committee and workgroup efforts.

~~2022~~

2023
INTEGRATED UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM DESCRIPTION

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CalOptima Health

2023

~~Utilization Management Program~~ ~~Description~~

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~~2021~~ UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

~~Himmet Dajee~~
Dabbah, Zeinab, M.D. *Date*
Deputy Chief Medical ~~Director~~Officer

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D. *Date*

Board of Directors Chair:

~~Supervisor Andrew Do~~Clayton M. Corwin **Date:**

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~~WE ARE CALOPTIMA~~

CASE MANAGEMENT PROCESS

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WE ARE CALOPTIMA HEALTH

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

Our Mission

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

~~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

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

~~**Our Values — CalOptima 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~~

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~~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 ~~2019, CalOptima's~~2022, CalOptima Health's Board and executive team worked together to develop the ~~2020–2022~~2023 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,~~by the CalOptima Health Board of Directors in June 2022. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima~~.~~ Health.

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?~~

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

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WHAT IS CALOPTIMA HEALTH?

Our Unique Dual Role

CalOptima ~~is~~Health operates as both a public agency and a community health plan.

~~As both~~In this dual role, CalOptima Health must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- 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. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (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 Health Medi-Cal.

Scope of Services

~~**Scope of Services**~~

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

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

- Specialty mental health and substance use disorder services are administered by the Orange County Health Care Agency (HCA).
- ~~Substance use disorder services are administered by HCA.~~
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima Health has developed specialized 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 Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through a specific Memoranda of

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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 Health Medi-Cal members into the scope of benefits provided by CalOptima Health. CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

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

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima Health has been offering OC to low- income seniors and people with disabilities who qualityqualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, and 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 and reside in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, a case manager or 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 workcase management team works 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.

Scope of Services

OneCare ConnectIn addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and

The OneCare Connect Cal MediConnect Plan (Medicare, CalOptima OC members are eligible Medicaid Plan) was launched in 2015 for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

1) The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in

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2015 for people who qualify for both Medicare and Medi-Cal. people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC) isprogram, as 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. The demonstration program will end on December , was discontinued 12/31, /2022, and members in OCC will transition to OC and .

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 benefitsmembers were bridged 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 worldwide 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 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 applyOneCare.

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 themcontinuity of care for their existing services.

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

In 2013, CalOptima Health 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 CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County, and be determined to be eligible:

- Eligible for nursing facility services by the State of California, and be able.
- 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

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~~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.~~Able to receive all non-emergent services within the CalOptima Health network.

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 Health PACE providers and are personally responsible for any unauthorized or out-of-network services.

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Quality PROGRAM INITIATIVES

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
2) Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
3) Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

These

~~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-19 PHE screening, vaccination 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.~~

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~~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 September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as detailed in its QI Work Plan.~~

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

~~The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, where people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM), and stresses DHCS' commitment to health equity, member involvement, and accountability in all program and initiatives.~~

~~Quality Strategy Goals~~

- ~~Engaging members as owners of their own care~~
- ~~Keeping families and communities healthy via prevention~~
- ~~Providing early interventions for rising risk and patient-centered chronic disease management~~
- ~~Providing whole person care for high-risk populations, addressing drivers of health~~

~~Quality Strategy Guiding Principles~~

- ~~Eliminating health disparities through anti-racism and community-based partnerships~~
- ~~Data-driven improvements that address the whole person~~
- ~~Transparency accountability, and member involvement~~

~~Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.~~top three priority goals were chosen to be aligned with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood, COVID-19 and other immunizations, including targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

Comprehensive Community Cancer Screening and Support Program

- CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence

rate for breast, cervical, colon and lung cancer in certain smokers.

- CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by a laser on detection and diagnosis of these four specific cancers. \

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

1) Community and member awareness and engagement
2) Access to cancer screening
3) Improved member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality driven incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. Beginning January 1, 2023, CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
   - CMS Quality
   - CMS Patient Experience
   - Leapfrog Hospital and Surgery Center Rating
   - Leapfrog Hospital Safety Grade
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
   - Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
   - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
   - Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
   - Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

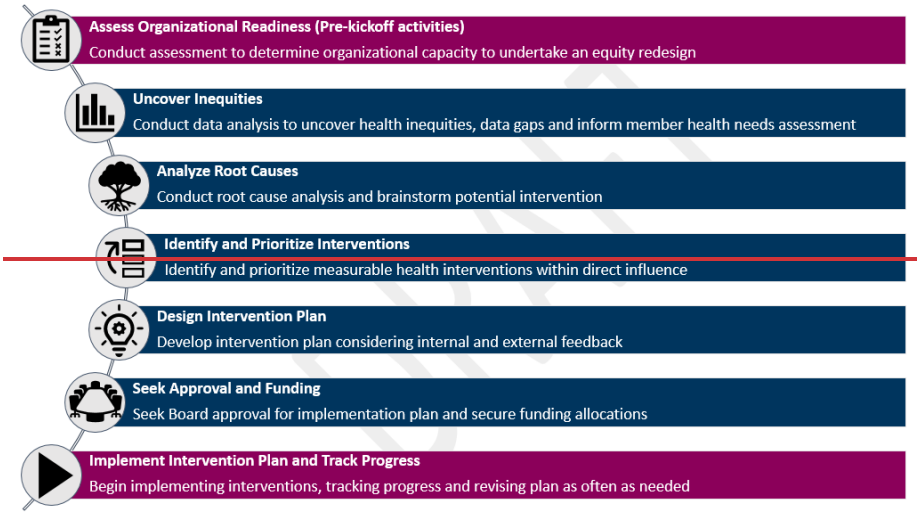
- ~~**Data** collection and stratification~~
- ~~Workforce diversity and cultural responsiveness~~
- ~~Reducing health care disparity~~

~~Health Equity Framework~~

~~Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (Centers for Disease Control and Prevention)~~

~~Social determinants of health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship, and age that affect health outcomes. (Henry J. Kaiser Family Foundation)~~

~~In response to CalOptima' strategic plan, staff began the process to identify and address health equity and social determinants of health (SDOH) for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes, designing comprehensive intervention plan, to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.~~



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~~integrated CCS services ~~to become a~~into CalOptima Health's Medi-Cal managed care plan benefit~~.~~, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (~~most~~ CCS and non-CCS services~~) under one entity~~ including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The ~~Whole Child Model (~~WCM~~)~~ services successfully transitioned to CalOptima Health in 2019 ~~and will continue indefinitely. Under~~as the 5th MCP awarded this pilot program. The HCA in Orange County~~,~~ continues to have the CCS program operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees ~~will remain~~. CalOptima works closely with

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~~HCA.~~

THE COUNTY CCS OFFICE TO ALIGN PROTOCOLS AND ENSURE CONTINUITY OF CARE FOR CCS-ELIGIBLE MEMBERS.CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reforms across Medi-Cal. CalOptima health implemented CalAim on 1/1/2022 and continues to work on expanding member access to services and supports. CalOptima's CalAIM program was established based upon three primary goals:

~~CalAIM has three primary goals:~~

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

Enhanced Care Management and Community Supports

~~On~~In a phased approach since January ~~1,~~ 2022, CalOptima ~~implemented two CalAIM components:~~Health has launched Enhanced Care Management (ECM) ~~and~~as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. ~~Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays~~Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 10 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria can be referred in so that they can receive the services.

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

1. Outreach and Engagement

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2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

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

- ~~Members experiencing homelessness (adults and children)~~
- ~~High utilizer adults~~
- ~~Adults with Serious Mental Illness (SMI)/substance use disorder (SUD)~~

~~Additionally, members participating in WPC and/or HHP will automatically transition into ECM.~~

~~HHP and WPC service providers will continue~~CalOptima Health has partnered with several local Community Based Organizations to provide ~~services under~~the 14 Community Supports ~~as CalOptima works~~ to ~~expand its network of~~our members in a medically appropriate, cost-effective manner. Community Supports ~~providers that have the expertise and capacity~~are alternatives to ~~provide the specific types of services needed. Members eligible for Community Services must consent~~covered services, which are provided to ~~participate and receive services.~~reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

The 14 Community ~~Support services include the following~~Supports are:

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

~~Beginning January 1, 2022, CalOptima will offer the following four, distinct~~ All authorizations for ECM and Community Supports are requested through the CalOptima Connect Portal and are managed by CalOptima's LTSS CalAIM team to determine eligibility

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. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California was discontinued 12/31/2022 and all members were bridged into

OneCare ensuring continuity of care for their existing services~~:~~

~~1. Housing Transition Navigation Services~~
~~1. Housing Deposits~~
~~2. Housing Tenancy and Sustaining Services~~
~~3. Recuperative Care~~

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

In 2013, CalOptima ~~will~~Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue ~~to assess the needs the members and collaborate with~~ living independently in the community ~~stakeholders to add new Community Supports~~.

To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:

- Eligible for nursing facility services by the State of California.
- Able to live safely at home or in a community setting with proper support.
- Able to receive all non-emergent services within the CalOptima Health network.

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.~~**2021-22 CalOptima Community Network (CCN) Pilot Program — Diabetes Mellitus (DM) Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics**~~

PACE participants must receive all needed services — other than emergency care — from CalOptima Health PACE providers and are personally responsible for any unauthorized or out-of-network services.

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

~~To address high rates of poorly controlled diabetics identified in CCN, the following pilot program was proposed and approved by the CalOptima Board.~~

~~1. Pharmacist Involvement and Intervention~~
~~CalOptima Pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dietitians/case managers.~~
~~2. Health Coach/Registered Dietitian Management Intervention~~
~~CalOptima Health Coaches will provide CCN-focused interventions, such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dietitians would also~~

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participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.

1. Non-Monetary Member Incentives

CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.

2. Provider Incentives

In order to have successful provider buy-in, CalOptima proposes offering provider incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will beare the responsibility of Medi-Cal Rx. CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities willto 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 OneCare, OneCare Connect or PACE.

Population Health Management (PHM) Program

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. l.Managing members with emerging risks
3. CalOptima Health's PHM ProgramConsidering 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 Program integrates physical health, behavioral health, LTSS, care coordination and

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complex case management to improve coordination of care between health care departments. The PHM includes basic population health management, care management, complex care management, ECM, and transitional care services.

CalOptima Health's PHM Program address the following four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings
4. Managing multiple chronic conditions

The ~~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 was 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 a public health issue 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~~

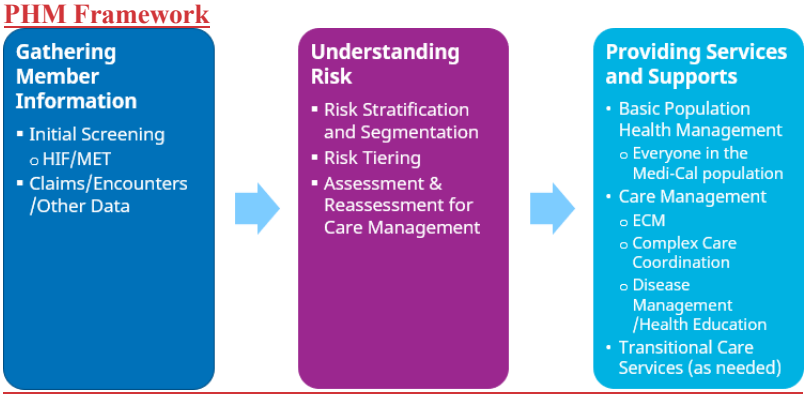
~~implemented, as part of the PHM program. Interventions for each project must:~~

- ~~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~~

PHM Framework outlines three key components for operationalizing the program: gathering information, understanding risk, and providing services.



The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM Program annually and uses key performance indicators, such as Primary Care, ambulatory care, ED visit and inpatient utilization and quality measures, such as HEDIS, to measure the effectiveness of the PHM Program.

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CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks~~/Contracted Network Providers~~ Entities
Providers have several options for participating in ~~CalOptima's~~CalOptima Health's programs providing health care to CalOptima Health members. Providers can participate through CalOptima Health Direct~~ Administration and/~~ (COD) network or through a Health Network (HN).

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) ~~and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN~~ or one of 12 HNs, representing more than 10,000 practitioners. CalOptima members that do not choose a PCP are provisionally assigned to CalOptima's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)
CalOptima **Health** Direct (COD) ~~CalOptima Direct~~ network is composed of two elements: CalOptima Health Direct- Administrative (COD-A) and the CalOptima Health Community Network- (CCN).

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

- CalOptima Health Community Network (CCN)

  - ~~The CalOptima Community Network~~ provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN eligible members ~~to select~~, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks
CalOptima Health has contracts with HNs that are delegated ~~HNs~~to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,~~500~~293

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primary care providers (PCPs), ~~more than~~ 8,~~900~~160 specialists, ~~41~~45 hospitals, 34 Community Health Centers clinics and ~~99~~98 long-term care facilities.

Provider Network Data (as of January 31, 2023)

	Number of Providers
Primary Care Providers	1,293
Specialists	8,160
Pharmacies	565
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	98

CalOptima Health contracts with the following HNs benefit programs:

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services~~-~~	SRG	SRG
AMVI/Prospect Medical Group		SRG
AMVI Care ~~Health Network~~Medical Group	PHC	PHC
Arta ~~–~~ Optum Care Network~~— Arta~~	SRG	SRG
CHOC Health Alliance~~-~~	PHC	
Family Choice Medical Group	~~PHC~~	SRG
Family Choice Health Services	HMO	
HPN~~-~~ ~~–~~ Regal Medical Group~~-~~	HMO	HMO
Kaiser Permanente	HMO	

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Monarch – Optum Care Network- ~~– Monarch~~	HMO	HMO

Noble Mid-Orange County	SRG	SRG
Prospect ~~Health Plan~~Medical Group	HMO	HMO
Talbert – Optum Care Network~~— Talbert~~	SRG	SRG
United Care Medical Group	SRG	SRG

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

- Utilization management-
- Basic and complex case management-
- Claims-
- Contracting and Provider Network development
- Provider Relations
- Credentialing of practitioners
- Customer services

- ~~Membership~~ membership Demographics

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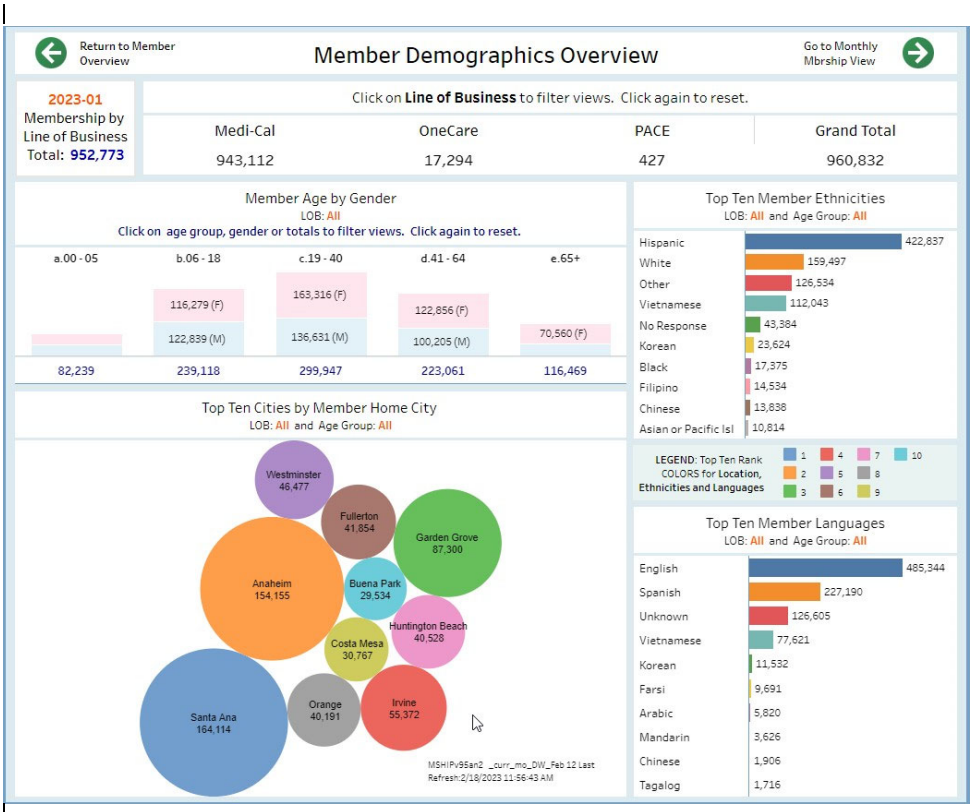

UTILIZATION MANAGEMENT PROGRAM

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CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2022

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

Membership Data from November 30, 2021, Financial Information

Total CalOptima Membership
867,182

Program	Members
Medi-Cal*	849,616
OneCare Connect	14,877
~~**OneCare (HMO SNP)**~~	~~2,274~~
Program of All-Inclusive Care for the Elderly (PACE)	415

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)		Languages Spoken (All Programs)		Medi-Cal Aid Categories	
10%	0 to 5	59%	English	41%	Temporary Assistance for Needy Families
27%	6 to 18	26%	Spanish	35%	Expansion
33%	19 to 44	10%	Vietnamese	9%	Optional Targeted Low-Income Children
18%	45 to 64	2%	Other	9%	Seniors
12%	65+	1%	Korean	5%	People with Disabilities
		1%	Farsi	<1%	Long-Term Care
		<1%	Chinese	<1%	Other
		<1%	Arabic		

UTILIZATION MANAGEMENT ~~PROGRAM~~

~~UM~~ Purpose

The purpose of the Utilization Management (UM) Program ~~Description~~ is to define ~~CalOptima's~~the oversight and delivery of CalOptima Health's structure ~~and~~, clinical processes ~~for~~, and programmatic approach to review ~~of~~ health care services, treatment, and supplies, ~~including assignment of responsibility to appropriate individuals, to deliver~~and provide quality, coordinated health care services to CalOptima Health members. ~~All~~ The Utilization Management Program includes review and analysis of utilization trends including identification of under and over-utilization to determine members are receiving appropriate services ~~are designed to~~. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, ~~cost effective~~ and timely manner by delegated and non-delegated providers.

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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~~.~~ within CalOptima Health's membership. Additionally, the scope of the UM program is to oversee continuity of care and access to appropriate services, providers and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, ~~and post-stabilization care across all~~long term care ~~settings~~and long-term services and supports. This includes preventive, emergency, primary, specialty, home- and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM PROCESS

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, care coordination and second opinions. All requests are reviewed against hierarchical guideline criteria and approved services must meet medical necessity criteria. The clinical decision process initiates upon receipt of a treatment authorization request. Request types 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 utilization trends and opportunities as well as identifying potential 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. All UM team members and oversight committees sign an annual attestation and are expected to abide by and uphold, CalOptima's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care services up to 12 months to requesting member's primary care providers, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring to CalOptima or a Health Network.

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 Health members. This includes but is not limited to:

- ~~Assist~~Assisting in the coordination of medically necessary ~~medical and behavioral~~physical health ~~care~~ , behavioral health, Long-Term Services and Supports (LTSS), Long Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.
- ~~Enhance~~Enhancing the quality of care for members by promoting coordination

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and continuity of care and service, especially during member transitions between different levels of care.

- ~~Provide~~Providing a mechanism to address concerns about access, availability and timeliness of care.
- Clearly ~~define~~defining staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- ~~Establish~~Establishing and ~~maintain~~maintaining processes used to review medical and behavioral health care and pharmacy 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~~Identifying and ~~refer high need~~referring members to Care Coordination, Case Management ~~programs, including,~~ Complex ~~and Enhanced~~ Case Management~~,~~ and Enhanced Care Management programs, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- ~~Promote~~Promoting a high level of member, practitioner and stakeholder satisfaction.
- ~~Protect~~Protecting the confidentiality of ~~member protected~~members health ~~information~~ and ~~other~~ personal information.
- ~~Identify~~Identifying and ~~report~~reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- ~~Identify~~Identifying and address over- and underutilization of services.
- ~~Monitor~~ Monitoring utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- ~~Promote~~Promoting improved member ~~health and well being~~outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- ~~Educate, monitor and evaluate practitioners and other providers, including delegated HNs on delivery of CalOptima's UM Program, policies and procedures on an ongoing basis.~~
- The LTSS team works collaboratively with CalOptima Health's HN's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM ~~staff~~staffing needs~~,~~ including clinical, non-clinical and ~~appropriate training delivered~~medical directors to address ~~those~~the needs of the members we serve.
- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

~~UM Program~~ Structure

The CalOptima Health UM Program is designed to work ~~collaboratively~~in alignment with delegated entities, ~~including, but~~for optimal health outcomes and includes but is not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community ~~in an effort~~ to ensure that the member receives appropriate, cost-efficient, quality-based health care.

The UM Program is reviewed ~~and~~, evaluated and revised as needed for effectiveness and compliance with

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the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks 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~~Health's network.

Additionally, the program 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 overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima Health delegates UM activities for a portion of the CalOptima membership to ~~entities~~Health Networks that demonstrate the ability to meet ~~CalOptima's~~CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health 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~~

CalOptima Health retains accountabilities 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~~CalOptima Health's Audit & Oversight department~~, Utilization Management~~ and reported to the Delegation Oversight Committee ~~(UMC)~~ and/or Quality Improvement Committee (QIC).
- ~~Regular~~ Annual and ad-hoc audits of delegated HNs' UM activities by ~~the~~CalOptima Health's Audit & 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 Health 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 Health takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation review, or de- delegation.

LONG-TERM SUPPORT SERVICES -(LTSS)

CalOptima Health 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 nursing and sub-acute facility services. for both adults and pediatrics. CalOptima Health's 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 peopel with disabilities. CalOptima LTSS monitors the levels of member access to, utilization, level of, access and satisfaction with the program, as well as its role inCommunity Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on 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 COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically, when appropriate.
- 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 Health 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, family and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima Health also covers ~~Alcohol Misuse Screening~~alcohol and ~~Counseling (AMSC) services~~drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) provided to members ~~18~~11 years and older ~~in the primary care setting~~, including pregnant women by providers within their scope of practice.

CalOptima Health 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 behavior 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.

CalOptima does not require members, or their practitioners undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at **855-877-3885**. A CalOptima Health representative will conduct a brief ~~mental health~~ telephonic screening. to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is used to make an initial determination of the member's impairment level. due to a mental health condition. If the member has mild to moderate impairments, the member will be offered behavioral health ~~practitioners~~ providers within the CalOptima ~~provider~~Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.

CalOptima Health directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

One Care (OC ~~and OCC~~)

CalOptima Health offers the following mental health services to OC ~~and OCC~~ members:

- ~~•~~ Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP) and partial hospitalization program (PHP)
- I Outpatient ~~mental health care including but not limited to~~ individual and group psychotherapy.

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- Outpatient medication management~~, psychological~~
- 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.~~

- Electro Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief ~~mental health~~ telephonic screening~~.~~ to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS)~~Specialty Mental Health Services~~ through the ~~Orange County Mental Health Plan~~OCMHP.

CalOptima Health 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~~

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

~~The~~ CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima Health 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~~CalOptima Health's state and federal contracts — and to ~~CalOptima's~~CalOptima Health'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 ~~services~~services provided to members. The Board ensures 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 Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. ~~CalOptima's~~CalOptima Health'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) has 15 voting members, each seat represents a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care Representative
- Medi-Cal Beneficiaries
- Medical Safety Net Representative
- Orange County Health Care Agency (standing seat~~)~~)
- Orange County Social Services Agency (standing seat~~)~~)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs

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- Seniors

~~**OneCare Connect Member Advisory Committee**~~

~~The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and has 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 has 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~~

Provider Advisory Committee

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

- Health networks~~-~~
- Hospitals~~-~~
- Physicians ~~(three seats)~~
- Nurse~~-~~
- Allied health services ~~(two seats)~~
- Community health centers~~-~~
- Health Care Agency (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~~CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.~~-~~

~~The~~Members of WCM FAC ~~has 11 voting seats:~~include~~-~~

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

~~Role of~~
CalOptima Health Officers~~ for UM Program~~
~~CalOptima's~~ Chief Medical Officer (CMO~~,~~), Chairperson of the Utilization Management Committee (UMC~~,~~), Executive Director of Clinical Operations, and/or any designee as assigned by ~~CalOptima's~~ CalOptima Health's Chief Executive Officer (CEO) are the senior ~~executives~~leaders 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~~CalOptima Health'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~~CalOptima Health's

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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, Care 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~~CalOptima Health'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~~CalOptima Health'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, Behavioral Health Integration (ED of BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED of BHI strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, ~~**Quality &**~~ Population Health Management (ED ~~of Q&~~PHM) ~~is responsible for facilitating~~oversees the ~~companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data~~development and ~~Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing~~implementation of company wide Population Health Management strategy to improve member experience, promote optimal health ~~plan with NCQA.~~outcomes, ensure efficient care and improve health equity. The ED ~~of Q&~~PHM serves as a member of the executive team, and with the CMO, DCMO and ~~ED of~~Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and ~~integrating~~integrate behavioral health across the ~~health care~~ delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* have primary assigned roles but may provide coverage and back up to other specialties as needed. All medical directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The medical director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health 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 uses 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. The medical director 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 biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIC.

- The medical director who oversees the behavioral health program is a participating member of the UMC, QIC and CPRC. The medical director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director supports the behavioral health aspects of the UM Program. The medical director also 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 Health 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.~~

- The medical director who oversees specialty programs and services is a key member of the medical management team and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM 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~~CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups and operational meetings.

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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~~operations. 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 Health in integrating physical and BH care services. ~~The director is responsible for~~This position provides leadership and direction to the ~~day-to-day operation of the program overseeing a team of care managers, medical case managers and medical authorization assistants who support all~~ BH UM ~~functions.~~team to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, 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~~,~~ for both physical and behavioral health (including onsite visits and process evaluation), 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 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. This position 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 agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position 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, Audit & Oversight oversees and conducts independent performance audits of CalOptima Health 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 Health policies, and industry best practices. The director ensures that CalOptima Health and subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is 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

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functions. The position interacts with the Board of Directors, CalOptima Health executives, departmental management, HN management and legal counsel.

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UM Staffing Resources

~~UM Resources~~

~~The following staff positions provide support for the UM department's organizational/operational functions and activities:~~

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The following UM Program roles

- provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Manager, Utilization Management RN/LVN (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.

Supervisor, Utilization Management RN/LVN(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 Health 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.

Manager, Utilization Management RN/LVN (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health 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.

Supervisor, Utilization Management RN/LVN (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 Health 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.~~

Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

The following staff positions provide support for the UM department's organizational/operational functions and activities:

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.~~, and is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient 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.~~

All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants are responsible for ~~effective, efficient and courteous interaction~~interacting with practitioners, members, family and other customers~~.~~. Staff members who are not qualified health care professionals are under the ~~direction~~direct supervision of ~~the~~a licensed ~~Case Manager.~~ clinician. Non-licensed team members process service requests that do not require clinical judgement be applied.
They perform routine medical administrative tasks specific to the assigned unit and office support functions. They ~~also~~can administratively authorize ~~requested~~ services according to departmental guidelines~~. All potential denial,~~ and~~/or modifications of provider service requests are discussed with~~ under the ~~appropriate Medical Director, who makes the final determination~~oversight of UM nurse reviewers and medical directors.

~~**Program Specialist** provides high level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.~~

Manager, Utilization Management (RN/LVN) (UM Monitoring) responsible for management of the day-to-day monitoring of UM activities, including monitoring of UM processes of Prior Authorization and Inpatient. Ensure that service standards are met, and operations are consistent with all regulatory requirements, accreditation standards and CalOptima Health policies and procedures.

Monitoring Nurses – UM (~~Medical Care Manager (~~Clinical Auditors,~~ LVN)) ~~provide~~conducts

routine oversight, monitoring ~~of referrals~~ and ~~specific~~auditing of internal UM ~~initiatives~~activities to ensure compliance with ~~UM requirements.~~state, federal and accreditation standards. ~~-~~ Monitoring activities include ~~monitoring referrals including~~ prior authorization and inpatient ~~and outpatient, WCM, findings on~~file reviews, addressing Correction Action Plans (~~CAPs) from both internal and external audits~~CAPS) findings, as well as identify opportunity for process improvement ~~when identified~~ during the monitoring process.~~—~~

Pharmacy ~~Department~~Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health 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.

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 Health delegated health plans and CalOptima Health 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 Health, as well as national practice guidelines and on an ongoing basis, research, 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~~interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

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 Health delegated health plans and CalOptima Health 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 Health, 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 Committee, interact frequently and independently with other department ~~directors, managers, and~~ staff as needed to perform the duties of the position, and have frequent ~~interaction~~interactions with external contacts, including the pharmacy benefit managers'

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clinical department.

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.

~~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 Staffing 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.~~

Manager, Long-Term Support Services (CBAS/LTC) ~~is expected to develop~~develops and ~~manage~~manages the LTSS department's work activities and ~~personnel~~team. The manager ensures that service standards are met, and operations are consistent with ~~CalOptima's~~CalOptima Health's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for ~~CalOptima's~~CalOptima Health'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.~~

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.~~

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 qualified CalOptima Health 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 act~~The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

~~**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 manager 1) leads 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) works 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) gathers and validates LTSS data to submit for DHCS reporting requirements and CalOptima QI Program; 4) works with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; 5) supports long-term departmental sustainability efforts; and 6) completes other activities related to the development and implementation of the LTSS program.~~

Program Manager, Sr., LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department.

Behavioral Health Integration Staffing Resources

~~The following staff positions provide UM support for~~

Manager, **Behavioral Health** ~~Integration (BHI) operations:~~

~~**Manager, Behavioral**~~ **CalOptima 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~~ manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima ~~policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.~~

~~**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, Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities~~policies and procedures, and regulatory and accreditation agency requirements.

~~**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.~~

~~**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 consulting 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.~~

~~**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. The manager uses medical criteria, and policies and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers.~~

~~**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.~~

~~**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.~~

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met.

Medical Case Managers (BH-RN/LVN or Licensed BH Clinician) provide inpatient and outpatient 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 psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Care Manager (BH) 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 BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support

functions.

Qualifications and Training

CalOptima ~~seeks to recruit~~Health hires highly qualified clinical 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 Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- ~~MIS~~Medical Management information system data entry
- ~~Application of Review Criteria/Guidelines~~
- ~~Appeals Process~~
- ~~Seniors and Persons with Disabilities Awareness Training~~
- ~~OC and OCC Training~~

- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima~~. 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~~ Health~~. 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~~.

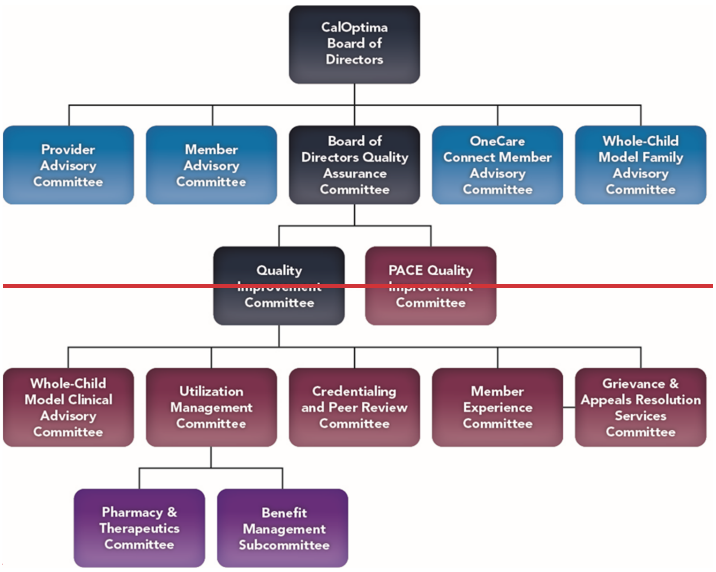
~~Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and 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 Health and its delegated ~~Utilization Review agents~~HN UM staff 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.

~~2022~~2023 UM Committee ~~Organization~~(UMC) Committee Structure

— Diagram



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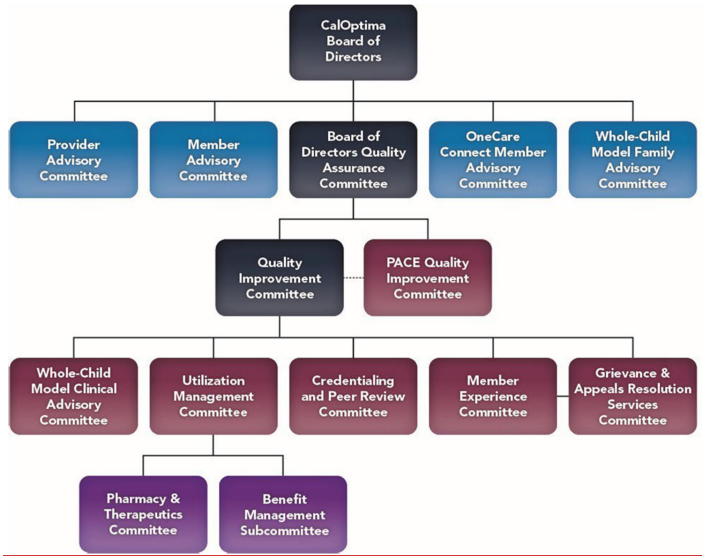

UMC-

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 Health 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.

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Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy addressing the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

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 Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the department of compliance and assigned privacy officer. During the onboarding process, all CalOptima Health employees — including contracted professionals who have access to confidential or member information — sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with ~~**UMC Scope and** Responsibilities~~

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

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- 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 Committee

~~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.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- UM Workgroup
- LTSS

UMC Membership

Voting Members:

- CMO
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees Specialty Programs
- Medical Director who oversees Whole-Child Model Program
- 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:

- Executive Director, Behavioral Health Integration
- Director, UM
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

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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~~CalOptima Health'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~~CalOptima Health'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 who oversees UM services— Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Behavioral Health Integration
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets quarterly, at minimum, 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, Executive Director of Behavioral Health Integration, 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 underutilization 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 uses 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 Health 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 Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by ~~CalOptima's~~CalOptima Health'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 Health 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

REVIEW AND AUTHORIZATION OF SERVICES

~~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 that are overseen by the department of compliance and assigned privacy officer. 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~~needs, evaluating available services within the local delivery system ~~on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines~~and applying evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting.

Covered services are those medically necessary health care services provided to members as outlined in ~~CalOptima's~~CalOptima Health's contract with CMS and the State of California for Medi-Cal~~, OC~~ and ~~OCC~~OC. Medically necessarily 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 children under 21, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illness conditions may be approved under Early and Periodic Screening, Diagnosis and Treatment (EPSDT).~~
- Medical necessity for members receiving MLTSS is determined by using a

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member's current needs assessment and is consistent with person-centered planning.

- 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 Health UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary~~, appropriate health care or health~~ services are ~~rendered~~provided in the most ~~cost-efficient manner, without compromising quality~~appropriate setting. 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~~CalOptima Health's UM department is responsible for the review and authorization of health care services for CalOptima Health 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 review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied ~~to all~~when reviewing prior ~~authorization,~~authorizations, inpatient and outpatient concurrent review, and retrospective review ~~determinations~~requests:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- ~~There is a set of written~~Evidenced based clinical criteria or guidelines ~~for Utilization Review that is based on sound medical evidence, is~~are applied 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 CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals~~.

- ~~Reasons~~Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, 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 in accordance with CalOptima Policy and Procedure HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process.~~

  timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- 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 Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service ~~authorization request; for OC/OCC all member notifications as listed above and notice of approval~~.
- OneCare members are notified in writing of any and all determinations.
- 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~~Supporting documents 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/ BMSC reviews the Prior Authorization List regularly, in conjunction with ~~CalOptima's~~CalOptima Health'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 Health 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 Health 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 Health 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~~CalOptima Health'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 Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. ~~Some referrals are auto adjudicated through~~The provider portal functionality includes referral intelligence rules ~~(RIR).~~, approved by clinical leadership to auto adjudicate when criteria is met. The referral intelligence rules and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization

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issues that require follow up.
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, includesHealth provides 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 an out-of-network provider for services that are not available from a qualified network provider, theThe 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

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 ana current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health 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 Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health 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~~

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and ~~CalOptima's~~CalOptima Health's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima Health 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 Health website.

The P&T Committee is responsible for development of the Medi-Cal physician-administered drug prior authorization list and 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 January 1, 2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medi-Cal/Medicare
CalOptima Health does not delegate OneCare 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.

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~~Behavioral Health Determinations~~

Behavioral Health Determinations

Medi-Cal
~~CalOptima's BH~~CalOptima Health's BHI department performs prior authorization review for ~~BHT~~BH 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 Health policy (approved by DHCS).

Medi-Cal/Medicare
CalOptima ~~has previously delegated Magellan Health Inc. to directly manage the BH UM functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's~~Health's BHI department ~~performed~~performs 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~~.~~, electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). 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.~~

Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima Health 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~~ or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health'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 timeframes 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 Health gives practitioners the opportunity to discuss BH UM denial decisions.

UM ~~Criteria~~Criteria

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, 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

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are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to: [RJ12]

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 Health Policy and Procedures and/or Clinical Benefits and Guidelines

~~5.~~

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. CMS Provider Manuals
   a. Internet-Only Manuals (IOMs) | CMS

~~2.~~3. Department of Health Care Services
   a. ~~Medi-Cal Provider Manual~~
   b. ~~http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp~~

~~3.~~4. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
   a. ~~https://www.nccn.org/professionals/physician_gls/default.aspx~~

~~4.~~5. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians

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and Gynecologists, Guideline Central, etc.)

~~a. https://www.guidelinecentral.com/library/~~

~~5.~~6. CalOptima Health 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, as well as based on the member's individual needs. 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~~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~~in conjunction with national guideline criteria in review for medical necessity~~ determinations, the Medical Director and UM staff make UM decisions that are consistent with~~. Additional guidelines ~~distributed to network practitioners. Such guidelines~~may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), 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**	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 Manua		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 Manua		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 Manua	X	X	X

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Office Visits (Follow-up)	MCG/Medi-Cal and Medicare Manua	X	X	X
Orthotics	MCG/Medi-Cal and Medicare Manua		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters fo 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 Manua		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 Determinatio 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 5133		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 5133		X	X
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services/Title 22, CCR, Sections 510 and 51303		X	X

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Long-Term Care: Intermediate Care Facility/Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services/Title 22, CCR, Sections 513 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 Treatmen (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 CalOptimaHealth may be contacted, when necessary to avoid a conflict of interest. CalOptima Health 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 CalOptimaHealth 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 CalOptima Health'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~~health website at www.~~caloptima~~CalOptima Health.org.

Inter-Rater Reliability (IRR)

At least annually, the CMO and ~~Executive Director,~~ Clinical Operations leadership assess the consistency with which Medical Directors and other ~~UM staff making~~ clinical ~~decisions~~decision makers apply UM criteria in decision-making. The assessment is performed as ~~a periodic~~an annual review ~~by the Executive Director, Clinical Operations or designee~~ to compare how ~~staff members manage~~reviewers' decision the same case ~~or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When~~. If an opportunity for improvement is identified through this process, UM and MD leadership takes corrective action. New UM staff ~~is~~are 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 Health 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. CalOptima Health has MD and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications ~~may include~~includes directly speaking with practitioners and members, ~~faxing~~fax correspondence, electronic or ~~telephone~~telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff ~~identifies~~identify themselves by name, title and CalOptima Health 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 Health. In cases requiring immediate response the vendor staff notifies CalOptima Health on-call nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM ~~physician~~MD. A log is ~~forwarded by the vendor to the UM department~~shared daily identifying ~~those issues that need~~activity and follow-up ~~by the UM staff~~needed the following day.

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Access to Physician Reviewer
The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical 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 Health Medical Director may be contacted by calling ~~the~~their direct dial number ~~for the Medical Director~~listed at the bottom of the provider denial notification~~.~~ or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the ~~CalOptima~~ Medical Director and requesting practitioner. ~~Whenever a~~All peer-to-peer ~~request is made,~~discussions are documented within clinical documentation ~~is added to the denied referral within Guiding Care, our UM system.~~platform

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~~ and following sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities, ~~that entity's~~utilize a Medical Director, or designee, ~~has~~as 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, retrospective, inpatient 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~~CalOptima Health'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~~CalOptima Health's UM Program ~~in no way prohibits~~does not prohibit or ~~otherwise restricts a~~restrict health care ~~professional~~ professionals from acting within the lawful scope of practice ~~from~~or advising or advocating on behalf of a member ~~who is his or her patient for~~including but not limited to 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~~Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

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Attachment A TIMELINES FOR MEDI-CAL

UM Decision and Notification Timelines

~~Medi-Cal (Excludes Pharmacy Requests)~~

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification ~~Timeframes~~(May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-~~Urgent~~urgent) Pre-Service~~*~~: Prospective or ~~concurrent~~outpatient service requests~~where no extension is requested or needed~~ ~~*Non pharmacy requests~~.	Approve, Modify, or Deny within 5 ~~working~~business days ~~1 of~~from receipt of ~~"all~~the information~"~~ reasonably necessary ~~and requested~~ to render a decision, and ~~in all circumstances~~ no ~~later~~longer than 14 calendar days ~~following~~from the receipt of the 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 making the decision.	**Practitioner:** **Electronic ~~or written communication within~~**Within 24 hours of making the decision. **Member:** ~~ADVERSE DETERMINATIONS ONLY~~ **Written ~~notice~~** Notice must be ~~dated and~~ postmarked within 2 ~~working~~business days of ~~making the~~ decision~~,~~ not to exceed 14 calendar days from receipt of the request ~~for service~~.

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Routine (Non-~~Urgent)~~ urgent) Pre-~~Service (Deferral),~~ Service – Extension ~~needed:~~ * Needed • Additional clinical information required. • ~~Requires~~Require consultation • by an ~~expert reviewer~~Expert Reviewer. • Additional examination or tests to be performed • ~~Extension is allowed ***only*** if member or provider requests the extension, or the Plan justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request. *.~~	~~May extend up to an additional 14 calendar days.~~ **~~Additional Requested Information is Received:~~** ~~A decision must be made~~Approve, Modify, or Deny within 5 ~~working days of receipt of requested information, not to exceed 28 calendar~~business days from receipt of the ~~original referral~~ information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • **~~Additional Information Incomplete or Not Received~~** ~~within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires not to exceed 28 days~~The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of decision to defer, in writing, within 5 business days of receipt of information reasonably necessary to render a decision and no longer than 14 calendar days from the receipt of initial request.	**Practitioner:** Within 24 hours of making the decision.	**~~Extension~~** **Practitioner:** ~~Oral or electronic notification within~~ **Electronic** Within 24 hours of making the decision ~~to delay~~. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. **Practitioner/Member:** Written ~~NOA "delay~~Notice of Action "Delay" notification ~~within 14~~within 14 calendar days of receipt of the request for services. • ~~The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. 3) The anticipated date when a decision will be rendered.~~ .

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	• 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.		
	Additional information received	**Practitioner:**	**Practitioner: Electronic**

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~~Attachment A~~

~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

	• If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.	Within 24 hours of making the decision.	Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
	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.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

Working days = Monday through Friday excluding California State Holidays–
https://www.ftb.ca.gov/aboutftb/holidays.shtml

~~Attachment A~~
~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

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~~Attachment A~~
~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Attachment A TIMELINES FOR MEDI-CAL

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification ~~Timeframes~~(May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited ~~Requests~~Authorization (Pre-Service~~)*~~) ~~No extension requested~~Provider or ~~needed~~ • ~~Requests where a provider indicates or the Plan~~CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. ~~function.~~ • All necessary information received at time of initial request.	Approve, ~~modify~~Deny, or ~~deny the request~~Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner:** ~~Oral or~~ **Electronic** ~~(fax) notification within~~Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member:** ~~ADVERSE DETERMINATIONS ONLY~~**Written** Written notice within 72 hours of the receipt of the request for services.

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~~Attachment A~~

~~TIMEFRAMES FOR MEDICAL DECISIONS AND~~

~~Expedited~~Expediated **Authorization (Pre-Service~~)*~~) -** Extension ~~needed:~~Needed Extension is ~~allowed only if~~extended when member or provider requests the extension, or ~~the Plan~~CalOptima Health justifies ~~the~~a need for additional information and ~~is able to~~can demonstrate how the ~~delay~~extension is i the member's best interest ~~of the member.~~ • . There is reasonable likelihood that receipt of such information would lead to approval of the request.	~~May extend up to 14 calendar days upon expiration of the 72 hour timeframe.~~ Approve, Deny, or Modify ~~Additional Requested Information is Received:~~ ~~A decision must be made~~ within ~~24~~72 hours ~~of~~from receipt of the request **Additional** ~~requested~~**clinical information~~.~~ required:** ~~**Additional Information Incomplete or not Received:** It will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.~~Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner~~/~~: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** ~~NOA "delay" notification~~ Written notice within 72 hours of the receipt of the request for services. ~~The extension must include:~~ ~~1. Justification for the delay, specifying the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required.~~ ~~2. The right to file an expedited grievance (oral o written) if they disagree wi the decision to grant an extension~~ ~~3. The anticipated date when a decision will be rendered.~~

~~Attachment A~~

~~TIMEFRAMES FOR MEDICAL DECISIONS AND~~

	~~Additional information received~~ • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision

~~Attachment A~~

~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

	~~Additional information incomplete or not received~~ • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health 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 of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. Extension: CalOptima Health may extend the timeframe 48 hours of up to 14 calendar days under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 calendar days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 calendar days after the oral notification.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.

~~Attachment A~~

~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Hospice - Inpatient Care	~~Within 24 hours of receipt of request.~~	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

[1] Working days=Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

~~Attachment A~~
~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Attachment B TIMELINES FOR OneCare

OneCare Decisions and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.

~~Attachment A~~

~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	~~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 received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1. Explain that CalOptima Health 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. 4. Provide instructions about the expedited grievance process and its time frames.

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~~TIMEFRAMES FOR MEDICAL DECISIONS AND~~

Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health 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 of the~~ receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medic al condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

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~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Type of Request	Decision	Important Message (IM) from Medicare	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

~~Attachment A~~

~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~ **Medi-Cal Pharmacy Prior Authorization Determination Timelines**

*Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health and Magellan Rx

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.
Standard (Non-urgent) Preservice – Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS 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.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.

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~~TIMEFRAMES FOR MEDICAL DECISIONS AND~~

Expedited (Urgent) Preservice/Concurrent - Delay Needed	- ~~CalOptima Health may delay the~~ timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS 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.
Post-Service/Retrospective	- A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.

Type of Request	~~Decision~~	Notification ~~Timeframes~~Timeline
~~**Concurrent*:**~~ ~~Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services).~~ ~~In the case of concurrent review, car shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by th treating provider that is appropriate f the medical needs of that patient.~~ ~~**CA H&SC 1367.01 (h)(3)**~~	~~Within 5 working days or less, consistent with urgency of member's medical condition.~~ ~~The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.~~**Standard (Non-urgent) Preservice** - All necessary information received at time of initial request.	~~**Practitioner / Member:**~~ ~~Oral or electronic notification within 24 hours of the decision, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3).~~ ~~**Practitioner/Member:** Written notice within 3 calendar days after the oral notification.~~ ~~For terminations, suspensions, or reductions of previously authorized services, Plans must notify beneficiaries at leas ten days before the date of the action with the exception o~~ - ~~circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.~~**Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

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TIMEFRAMES FOR MEDICAL DECISIONS AND

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:** Written notice within 30 calendar days from receipt of request. **Member:** Adverse Determination Only within 30 days of receipt of request
Post-Service*: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the pla is aware that additional information i required to render a decision, but no more than 30 days from the receipt the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Practitioner:** Written notice within 30 calendar days from receipt of the Request. **Member:** Within 30 days of receipt of request

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~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- ~~**Type of Request**~~**Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed - Additional clinical information not received within initial 14 calendar days.	~~**Additional Clinical Information Incomplete or Not Received:**~~ - ~~Decision must be made with the information that is available by the end of the 30th~~**Provider:** Delay notice sent within 14 calendar ~~day given~~days of receipt of the original request to ~~provide~~delay the timeframe for an additional ~~information~~14 calendar days. - **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
~~Within 24 hours of making the decision.~~**Expedited (Urgent) Preservice/Concurrent - Delay Needed** - Additional clinical information not received within initial 72 hours.	~~**Practitioner:**~~ - ~~Oral or electronic notification~~**Provider:** Delay notice sent within ~~24~~72 hours of ~~making~~receipt of the ~~decision~~original request to delay the timeframe for up to an additional 14 calendar days. - **Member**~~ Adverse Determination Only: Written~~**:** Delay notice sent within ~~2 working days~~72 hours of ~~making~~receipt of the ~~decision~~original request to delay the timeframe for up to an additional 14 calendar days.

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Post-Service/Retrospective	- **Provider:** Within 30 calendar days of receipt of the request. - **Member:** Within 30 calendar days of receipt of the request.

Medicare

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service: No extension requested or needed	Within 5 working days of receipt "all information" reasonably necessary to render a decision, and in all circumstances no longer than 14 calendar days. "all information" means: Complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice 2 working days of making the decision, not to exceed 14 calendar days from receipt of the request for service.
Routine (Non-Urgent) Pre-Service (Deferral) Extension needed • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests and justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request. An extension ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	May extend up to an additional 1 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 1 calendar days from receipt of the original referral request. **Additional Information Incomplete or Not Received** A written member notice of denial issued within 28 calendar days from the receipt of the original referral request.	**Extension - Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** • Written notice within 14 calendar days of receipt of request. The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if the 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 -** **Practitioner/Member:** Written notice within 2 working days of making the decision, not to exceed 28 calendar days from receipt of the request.

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OneCare Pharmacy Part D Determination Timelines

Type of Request	~~Decision~~Determination Timeline
~~**Expedited Authorization (Pre-Service):**~~ ~~No extension requested or needed~~ ~~Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.~~ ~~All necessary information received at time of initial request.~~**Standard (Non-urgent) Preservice/Concurrent**	~~**Practitioner:**~~ ~~Oral or electronic notification within 24 hours of making the~~ A decision ~~not to exceed~~ to approve or deny is required within 72 hours ~~from~~of receipt of the request~~.~~ ~~**Member, OCC and OC Medicare Services Only:**~~ ~~Oral notification within 72 hours from receipt of request.~~ ~~**Practitioner /**~~ or prescriber supporting statement for exception requests (not to exceed seven calendar~~**Member: Written** notice within 2 working~~ days of making~~ from when the ~~decision.~~request was received).

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Expedited ~~Authorization (Pre Service):~~ **~~Extension needed~~** ~~Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.~~(Urgent) Preservice/Concurrent	~~May extend up to 14 calendar days upon expiration of the 72 hour timeframe.~~ ~~Notify practitioner and member using the "delay" template and insert specifics including~~ ~~1. Justification for the delay, information that has not been received, what consultation is needed and/or the additional examination or testes required to make a decision.~~ ~~2. The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.~~ ~~3. The anticipated date when a decision will be rendered.~~ **~~Additional Requested Information is Received:~~** A decision ~~must be made~~ to approve or deny is required within ~~1 working day~~24 hours of receipt of ~~requested information.~~the request or prescriber supporting statement for exception requests (not to exceed seven calendar days **~~Additional Information Incomplete or not Received~~** ~~Any decision delayed beyond the timeframe limits is considered a denial and must be processed immediately as such.~~from when the request was received).

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Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.

Type of Request	Notification ~~Timeframes~~Timeline (Member and Prescriber)
Standard (Non-urgent) Preservice/Concurrent~~:~~ ~~Concurrent review of treatment regimen already in place, (inpatient, ongoing/ambulatory services).~~ ~~In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.~~ ~~CA H&SC 1367.01 (h)(3)~~	Within ~~5 working days or less, consistent with urgency~~72 hours of ~~member's medical condition.~~ ~~The decision, based on medical necessity, shall be made in a timely fashion appropriate~~receipt of the request or prescriber supporting statement for ~~the nature of the enrollee's condition,~~ exception requests (not to exceed ~~5 business~~seven calendar days from the ~~plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.~~date of the original request).

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~~**Post-Service/Retrospective Review:**~~ ~~All necessary information received at time of the request.~~**Expedited (Urgent) Preservice/Concurrent**	Within ~~30~~24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from ~~receipt~~the date of the original request~~.~~).

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Post-~~Service:~~ ~~Extension needed~~service/Retrospective	~~**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 receip 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.~~Within 14 calendar days of the initial receipt of the request.

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Type of Request	Decision	Notification Timeframes
Hospice – Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice within 2 working days or making the decision.

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal Pharmacy Timeframes for Determinations	OC and OCC Pharmacy Timeframes for Determinations (Part D)
Standard (Non-urgent) Pre-Service: Within 24 hours a decision to approve, modify, deny or defer is required. Standard (Non-urgent) Pre-Service, Extension Needed: Within 5 working days of receiving needed information, but no longer than 14 calendar days Expedited (Urgent) Pre-Service/ Concurrent: Within 24 hours a decision to approve, modify, deny or defer is required. Expedited (Urgent) Pre-Service/ Concurrent, Extension Needed: Within 72 hours of the initia request Post-Service/Retrospective: Within 30 days of receipt	Routine: 72 hours Urgent: 24 hours Retrospective: 14 days
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 decision. 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 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.**

~~Medi-Cal Pharmacy~~ ~~Timeframes for Determinations~~	~~OC and OCC Pharmacy~~ ~~Timeframes for Determinations (Part D)~~
	~~For standard requests:~~ ~~Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar~~ ~~days of the oral notification.~~ ~~For retrospective requests:~~ ~~Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 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 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.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health 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~~notify CalOptima Health of a ~~Prior Authorization Request for~~ Post-Stabilization ~~Services when~~request for services prior to admission. Once a member ~~who has received~~is stabilized after 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.~~services The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) ~~do not~~ apply to both contracted and noncontracted providers in ~~CalOptima's~~CalOptima Health's Medi-Cal program. CalOptima Health or a HN shall approve or deny a prior authorization request for post-stabilization services ~~and~~if all information reasonably necessary ~~and requested~~ to render a decision is received from a ~~non-contracted~~ hospital within 30 minutes ~~after receiving such request and information for Medi-Cal members, and within~~ or 60 minutes ~~after receiving such request and information from a non-contracted hospital~~ for OC ~~or OCC~~ members. If CalOptima Health or the HN does not respond within the prescribed timeframe, 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 require prior authorization and have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for ~~concurrent~~pre-service review. ~~The Director of UM, or designee, reviews the request for retrospective authorization.~~

Retrospective Authorization ~~shall~~is only ~~be~~ permitted in accordance with CalOptima Health Policy and Procedure GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which is as follows:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, or OneCare program, as applicable, at the time of service.

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 of 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~~Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient ~~prior-authorized~~ admissions within ~~one (1) business day following the actual~~24 hours of admission. The ~~admission/concurrent~~inpatient 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 but is not limited to:

- Clinical information to support the appropriateness and level of service ~~proposed~~being provided
- 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~~requested
- 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 timeframe appropriate for the type of decision (i.e., pre-service and post-service).~~

~~Concurrent review for inpatient hospitalization is conducted throughout the~~Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the members inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. ~~Concurrent~~Inpatient 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 clinical 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,~~refers 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~~ If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA) letter is issued immediately by fax ~~or via overnight certified mail~~and telephone to the attending physician, hospital and mailed to the member for OC members verbal notification is also provided.

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~~inpatient admission, focused on 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~~issue, the concern is referred to CalOptima Health QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, ~~cost-effective,~~ quality-driven treatment intervention for post-hospital care needs. It is a ~~cooperative~~coordinated effort among the facility and CalOptima Health and includes but is not limited to attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, 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 multidisciplinary 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~~Inpatient 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 Health 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 timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at ~~the~~a sixth grade reading 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 timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS 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 Health 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~~

Grievance and Appeal Process

CalOptima Health has a comprehensive review system to address matters when Medi-Cal,

OC ~~or OCC~~ 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 Health. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to ~~CalOptima's~~CalOptima Health'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 Health Member Complaint Policy. HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Appeal Process. ~~This process includes~~These processes include but are not limited to:

- 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~~all of CalOptima Health Networks except Kaiser are handled by CalOptima Health GARS. CalOptima Health works collaboratively with the community provider or delegated entity in gathering 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 Health 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~~a confidential and peer protected process.

~~Upon request,~~All members ~~can~~ have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Health Customer Service department.

Expedited Appeals and 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, risk for adverse health outcome if not decisioned quickly, 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~~regarding 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~~Expedited appeals and grievances 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 Fair Hearing

CalOptima Health 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 Health and ~~the HMOs, PHCs and SRGs~~delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Fair 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 Health is notified when a request is made by a member or member representative. CalOptima Health supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health 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~~CalOptima Health's QI department for further research and reporting to government and/or regulatory agencies.

~~LONG-TERM SERVICES AND SUPPORTS~~

LONG-TERM SERVICES AND SUPPORTS

LTC

The LTC case management program includes authorizations for the following facilities:~~-~~

- NF-A, NF-B , subacute 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 Health of admissions within 21 days. ~~There are two types of NFs: On-site NFs where CalOptima nurses make monthly or bimonthly 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~~Nurse Case Managers 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 on-site 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, CalAIM or ~~to a~~ CBAS ~~facility~~. Referrals to case management can also be made upon discharge when a ~~member~~member's needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff ~~through monthly on-site 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. A new benefit launched in October 2022 allow for members to receive

Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

MSSP

~~CalOptima has responsibility for the payment of MSSP in the County of Orange for individuals who have Medi-Cal.~~CalOptima Health is an approved MSSP site through California Department of Aging (CDA).. The program provides services and support to help people 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 resources, 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 leadership team, the ~~Clinical Performance Excellence Committee~~UM workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews the Over/Under Utilization ~~Dashboard~~report 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/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

~~The following are measures~~Under and Over Utilization is tracked and monitored ~~for over/under utilization~~through the following areas and trends:

- ER ~~admissions~~visits per 1000
- Bed days per 1000
- Admits per 1000

- Average length of stay per 1000
- Readmission rates
- ~~Denial rates~~
- Pharmacy utilization measures
- ~~Appeal overturn rates – provider per 1,000 per year~~
- Member grievances per ~~thousand~~1000
- ~~Outliers~~Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and 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~~Deputy 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 Health provides an explanation of the GARS process, State 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 Health QI department for investigation and resolution.

Annually, CalOptima Health 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 areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern, which may include staff retraining and member/provider education.

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.
Program Updates and/or Changes

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Complex Case Management process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year.

Updates and/or changes to the CCM program and process include but are not limited to the following:

- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Provide targeted outreach and case management to support members who utilize primarily the emergency department for care and develop best practices for outreaching these members and improving their overall care.
- Continue development of specialized outreach and management for special populations, such as members struggling with homelessness, pain, or behavioral health issues. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.
- California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program went into effect in 2019.
- Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members.
- Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx.
- The OneCare Connect program ended effective December 31, 2022 and members transitioned to the OneCare (D-SNP) program effective January 1, 2023.
- Another component of CalAIM, Population Health Management was launched effective January 1, 2023 with a phased implementation.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The teams are multidisciplinary, and are composed of nurse Case

Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and Member Liaison Specialists, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk Assessment Team, Health Network Liaison Team, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima mission and vision.

Director of Care Management directs all Case Management programs for CalOptima members to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for all departmental compliance with all local, state, and federal regulations and ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The incumbent works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and projects associated with the department to ensure compliance with department policies and procedures, along with the implementation of assigned projects. The incumbent may be required to attend joint operational and community meetings. The incumbent is responsible for monitoring of case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The incumbent will provide guidance to staff or will directly handle complex case management referrals. The incumbent will be accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The incumbent will serve as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager will facilitate communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Medical Case Manager (Oversight) is responsible for providing ongoing case

management services for CalOptima members. The position facilitates communication and coordination among all participants of the health care team and the member to ensure that the services are provided to promote quality, cost-effective outcomes. The Oversight Case Manager completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to address medical, behavior, and psychosocial concerns. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.

Medical Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager or the Gerontology Resource Coordinator. The Medical Assistant performs medical and administrative routine tasks specific to the assigned unit, and office support functions. The Medical Assistant may also authorize requested services according to departmental guidelines.

Social Worker provides administrative case management and coordination of benefits for carved-out services. The Medical Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Medical Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinator support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCC will identify barriers to members' care and assist in in improving these barriers for all levels of care. The incumbent will work closely with the PCP and health care team to ensure member access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and mailings, applying general business practices, as well as CalOptima policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects, and ensures that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the incumbent performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The incumbent interacts with

other internal CalOptima departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Licensed Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

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

Each new employee is provided an 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 description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- Seniors and Persons with Disabilities Awareness Training
- OneCare Model of Care Training
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- QI Referral Process

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for each licensed CM employee. Licensed nursing staff is monitored for appropriate application of Review Criteria/Guidelines, NCQA requirements, and case management documentation. 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 Case Management staff on an annual basis. Delegated Health Network staff participates annually in CalOptima Health model of care training.

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 Health 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 Health. CalOptima Health 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, continuity of care may also be explored to continue treatment with the provider in certain situations. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health or a member terminates from CalOptima Health to a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk stratification process or Predictive Modeling Tool
- Health Information Form (HIF) or Member Evaluation Tool (MET), if available

The avenues for referring a member for case management are:

- Member self-referral
- Member's authorized representative/family referral
- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN/SRG/PMG referral
- Utilization Management referral
- Long Term Services and Supports referral

The case management program includes:

- Documented process to assess the needs of member population.
- Development of the program through use of evidenced based guidelines.
- Defined program goals.
- Standardized mechanisms for member identification through use of data.
- Multiple avenues for referrals to case management.
- Following members across the continuum of health care from outpatient or ambulatory to inpatient

settings.

- Process to inform eligible members of case management services, and the ability to elect or decline services.
- Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.
- Use of evidenced-based clinical practice guidelines or algorithms.
- Initial assessment and ongoing management process.
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.
- Developing prioritized goals that consider the member or caregiver's goals and preferences.
- Developing member self-management plans.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to ensure quality, timeliness, and effectiveness of services.
- Analyzing data and member feedback to identify opportunities for improvement.
- Mechanism for identification and referral of quality-of-care issues to QI Department.
- Coordination of carved out services, such as Denti-Cal
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of member's health care status and needs, including condition-specific issues:

- Member's right to accept or decline case management services
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Evaluation of behavioral health, cognitive function, and substance use disorder
- Evaluation of cultural and linguistic needs, preferences or limitations
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, preferences or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)
- Assessment of social drivers of health (SDOH)
- Review current status and treatment plan
- Identifies barriers to quality, cost-effective care and fulfilling the treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Evidence-based clinical guidelines or algorithms to conduct assessment and management

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan that identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes the following:

- Development of prioritized SMART goals that take into account:
- Member or caregiver's goals or preferences
- Member or caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with self-management plan

- Scheduled time frame for follow-up and communication with members
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfer
- Collaborative approaches to be used, including family/caregiver participation

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The Case Management Department assists 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.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services
- California Children's Services (CCS)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver (formerly NF/AH Waiver)
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)
- Tuberculosis Program (Direct Observation Therapy)
- Collaborate with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Members with end stage renal disease (ESRD) and a comorbid condition of prostate cancer may not meet criteria for transplant based on guidelines. Lack of transportation may create obstacles to care, yet the member

may not meet criteria for non-emergency medical transportation. Members who are at the end-of-life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member's preferences.
- PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the member, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the member's treatment plan
- Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan
- Identification of the need for medical, specialty or ancillary referrals
- Referrals to case management and/or disease management

Complex Case Management

Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:

1. Basic Case Management Services
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optima health or improved functionality
4. With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually

Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and

who needs assistance in facilitating the appropriate delivery of care and services.

The members in Complex Case Management usually:

1. Are at high risk; or
2. Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:
3. Spinal Injuries
4. Transplants
5. Cancer
6. Serious Trauma
7. AIDS
8. Multiple chronic illnesses
9. Chronic illnesses that result in high utilization
10. Have a complex social situation that affects the medical management of their care; or
11. Require extensive use of resources; or
12. Have an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima uses this criteria when data mining and as a guideline for internal and external referral sources to identify appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.

Case Management staff ensures coordination of care with other entities that provide services for Children with Special Health Care Needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

The goals of CSHCN Case Management are to:

- Collaborate with family and providers to develop an Individualized Care Plan
- Facilitate member access to needed services and resources
- Prevent duplication of services
- Optimize member's physical and emotional health and well-being
- Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) children and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or

specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.

The Whole Child Model program includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results

Transitional Care Services (TCS)

Transitional Care Services (TCS) are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facility. For members enrolled with Case Management, Case Managers will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

The Case Manager is responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The Case Manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the Case Manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.

Special Programs

Transplant Program

The CalOptima Health 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 or CMS certified Centers for OneCare. Case Management will follow the member and assist as needed through the transplant evaluation process, while they are waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed the transplant continuum. 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 Health monitors and maintains oversight of the Transplant Program and report to UM Committee to oversee the accessibility, timeliness, and quality of the transplant protocols.

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2023
INTEGRATED UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM DESCRIPTION

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2023 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Dabbah, Zeinab, M.D. ***Date***
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

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

Board of Directors Chair:

Clayton M. Corwin **Date:**

_____ _____

Contents

CASE MANAGEMENT PROCESS

WE ARE CALOPTIMA HEALTH

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

Our Mission

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

Our Vision

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

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 2022, CalOptima Health's Board and executive team worked together to develop the 2023 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved by the CalOptima Health Board of Directors in June 2022. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima Health.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

WHAT IS CALOPTIMA HEALTH?

Our Unique Dual Role

CalOptima Health operates as both a public agency and a community health plan.

In this dual role, CalOptima Health must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- 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. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (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 Health Medi-Cal.

Scope of Services

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

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

- Specialty mental health and substance use disorder services are administered by the Orange County Health Care Agency (HCA).
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima Health has developed specialized 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 Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through a 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 Health Medi-Cal members into the scope of benefits provided by CalOptima Health. CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

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

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima Health 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 and dual eligible members in Orange County.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B and reside in Orange County. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, a case manager or 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 case management team works 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.

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. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California, was discontinued 12/31/2022 and all members were bridged into OneCare ensuring continuity of care for their existing services.

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

In 2013, CalOptima Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.
To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:

- Eligible for nursing facility services by the State of California.
- Able to live safely at home or in a community setting with proper support.
- Able to receive all non-emergent services within the CalOptima Health network.

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 Health PACE providers and are personally responsible for any unauthorized or out-of-network services.

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Quality PROGRAM INITIATIVES

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
2) Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
3) Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

These top three priority goals were chosen to be aligned with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood, COVID-19 and other immunizations, including targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

Comprehensive Community Cancer Screening and Support Program

- CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon and lung cancer in certain smokers.
- CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by a laser on detection and diagnosis of these four specific cancers. \

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

1) Community and member awareness and engagement
2) Access to cancer screening
3) Improved member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality driven incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. Beginning January 1, 2023, CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
    - CMS Quality
    - CMS Patient Experience
    - Leapfrog Hospital and Surgery Center Rating
    - Leapfrog Hospital Safety Grade

2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
    - Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
    - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
    - Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
    - Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

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 integrated CCS services into CalOptima Health's Medi-Cal managed care plan benefit, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (CCS and non-CCS services including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The WCM services successfully transitioned to CalOptima Health in 2019 as the 5th MCP awarded this pilot program. The HCA in Orange County continues to have the CCS program operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees. CalOptima works closely with the county CCS office to align protocols and ensure continuity of care for CCS-eligible members. California Advancing and Innovating Medi-Cal (CalAIM)California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reforms across Medi-Cal. CalOptima health implemented CalAim on

1/1/2022 and continues to work on expanding member access to services and supports. CalOptima's CalAIM program was established based upon three primary goals:

1. Identification and management of member risk and need through whole person care approaches and addressing social determinants of health.
2. Development of a consistent and seamless delivery of care and services through reduction of complexity and increase inflexibility.
3. Improved outcomes, reduction of health disparities, and transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

In a phased approach since January 2022, CalOptima Health has launched Enhanced Care Management (ECM) as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 10 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria can be referred in so that they can receive the services.

ECM providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with several local Community Based Organizations to provide the 14 Community Supports to our members in a medically appropriate, cost-effective manner. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

The 14 Community Supports are:

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

13. Sobering Centers
14. Asthma Remediation

All authorizations for ECM and Community Supports are requested through the CalOptima Connect Portal and are managed by CalOptima's LTSS CalAIM team to determine eligibility

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. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California was discontinued 12/31/2022 and all members were bridged into OneCare ensuring continuity of care for their existing services

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In 2013, CalOptima Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:

- Eligible for nursing facility services by the State of California.
- Able to live safely at home or in a community setting with proper support.
- Able to receive all non-emergent services within the CalOptima Health network.

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 Health PACE providers and are personally responsible for any unauthorized or out-of-network services.

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances are the responsibility of Medi-Cal Rx. CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities to 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 OneCare or PACE.

Population Health Management (PHM) Program

CalOptima Health's PHM Program 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 Program integrates physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. The PHM includes basic population health management, care management, complex care management, ECM, and transitional care services.

CalOptima Health's PHM Program address the following four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings
4. Managing multiple chronic conditions

The PHM Framework outlines three key components for operationalizing the program: gathering information, understanding risk, and providing services.

PHM Framework

The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM Program annually and uses key performance indicators, such as Primary Care, ambulatory care, ED visit and inpatient utilization and quality measures, such as HEDIS, to measure the effectiveness of the PHM Program.

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities
Providers have several options for participating in CalOptima Health's programs providing health care to CalOptima Health members. Providers can participate through CalOptima Health Direct (COD) network or through a Health Network (HN).

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) or one of 12 HNs, representing more than 10,000 practitioners. CalOptima members that do not choose a PCP are provisionally assigned to CalOptima's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)
CalOptima Health Direct (COD) network is composed of two elements: CalOptima Health Direct- Administrative (COD-A) and the CalOptima Health Community Network (CCN).

- CalOptima Health Direct-Administrative (COD-A) is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima Health's OneCare programs), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County.
- CalOptima Health Community Network (CCN)provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN eligible members, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks
CalOptima Health has contracts with HNs that are delegated to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,293 primary care providers (PCPs), 8,160 specialists, 45 hospitals, 34 Community Health Centers clinics and 98 long-term care facilities.

Provider Network Data (as of January 31, 2023)

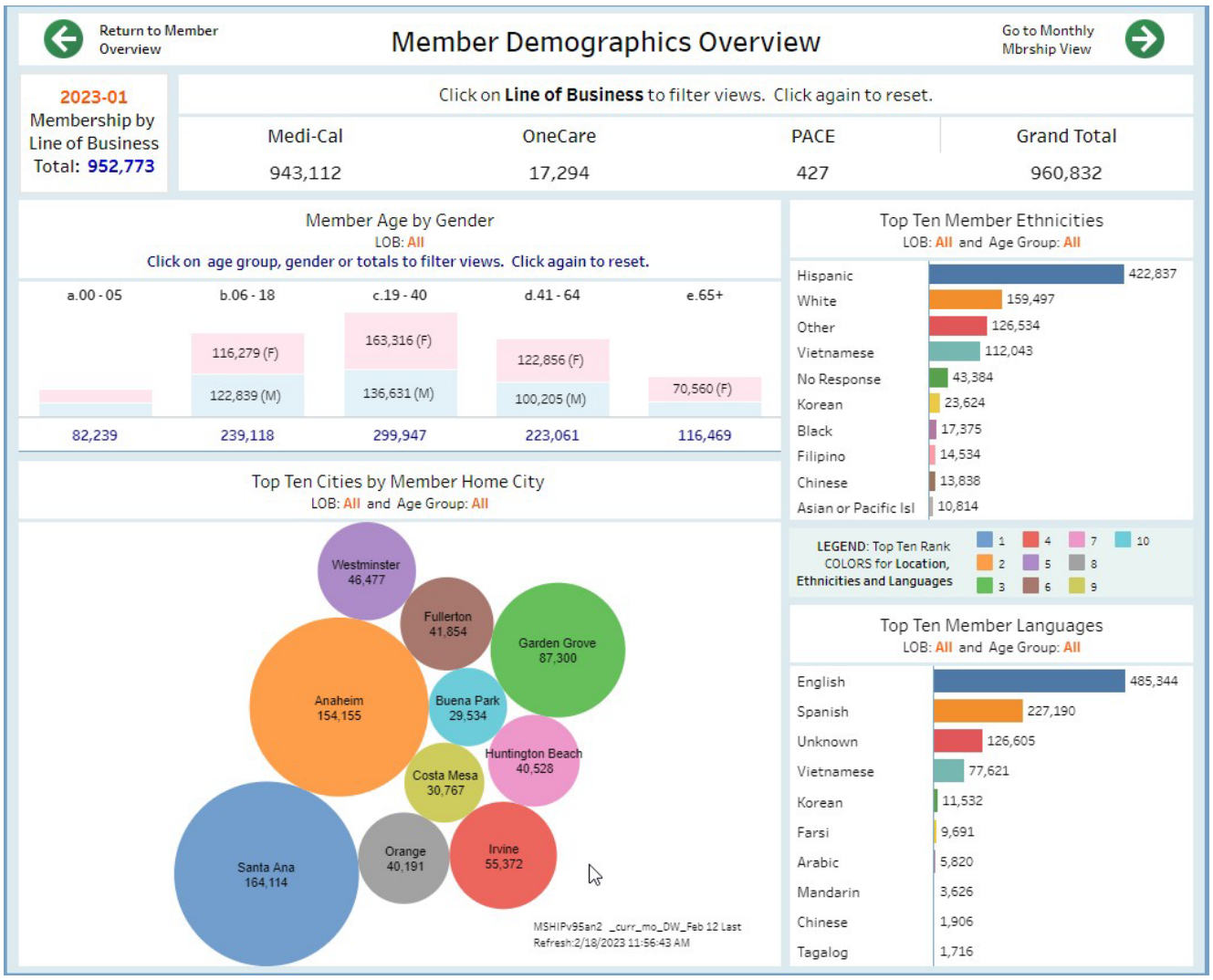
	Number of Providers
Primary Care Providers	1,293
Specialists	8,160
Pharmacies	565
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	98

CalOptima Health contracts with the following HNs benefit programs:

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI/Prospect Medical Group		SRG
AMVI Care Medical Group	PHC	PHC
Arta – Optum Care Network	SRG	SRG
CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
Kaiser Permanente	HMO	
Monarch – Optum Care Network	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
Talbert – Optum Care Network	SRG	SRG
United Care Medical Group	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
- Basic and complex case management
- Claims
- Contracting and Provider Network development
- Provider Relations
- Credentialing of practitioners
- Customer services membership Demographics



UTILIZATION MANAGEMENT PROGRAM

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach to review health care services, treatment, and supplies, and provide quality, coordinated health care services to CalOptima Health members. The Utilization Management Program includes review and analysis of utilization trends including identification of under and over-utilization to determine members are receiving appropriate services. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an 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 within CalOptima Health's membership. Additionally, the scope of the UM program is to oversee continuity of care and access to appropriate services, providers and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, long term care and long-term services and supports. This includes preventive, emergency, primary, specialty, home- and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM PROCESS

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, care coordination and second opinions. All requests are reviewed against hierarchical guideline criteria and approved services must meet medical necessity criteria. The clinical decision process initiates upon receipt of a treatment authorization request. Request types 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 utilization trends and opportunities as well as identifying potential 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. All UM team members and oversight committees sign an annual attestation and are expected to abide by and uphold, CalOptima's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care services up to 12 months to requesting member's primary care providers, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring to CalOptima or a Health Network.

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 Health members. This includes but is not limited to:

- Assisting in the coordination of medically necessary physical health, behavioral health, Long-Term Services and Supports (LTSS), Long Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.
- Enhancing the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between

different levels of care.

- Providing a mechanism to address concerns about access, availability and timeliness of care.
- Clearly defining staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- Establishing and maintaining processes used to review medical and behavioral health care and pharmacy 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.
- Identifying and referring members to Care Coordination, Case Management, Complex Case Management and Enhanced Care Management programs, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promoting a high level of member, practitioner and stakeholder satisfaction.
- Protecting the confidentiality of members health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identifying and address over- and underutilization of services. Monitoring utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- Promoting improved member outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- The LTSS team works collaboratively with CalOptima Health's HN's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM staffing needs including clinical, non-clinical and medical directors to address the needs of the members we serve.
- Provide continuous training for competency, 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 CalOptima Health UM Program is designed to work in alignment with delegated entities, for optimal health outcomes and includes but is not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community to ensure that the member receives appropriate, cost-efficient, quality-based health care.

The UM Program is reviewed, evaluated and revised as needed for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks at least annually. 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's network. Additionally, the program 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 overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima Health delegates UM activities for a portion of the CalOptima membership to Health Networks that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures.

CalOptima Health retains accountabilities 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 Health's Audit & Oversight department and reported to the Delegation Oversight Committee and/or Quality Improvement Committee (QIC).
- Annual and ad-hoc audits of delegated HNs' UM activities by CalOptima Health's Audit & 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 Health 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 Health takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation review, or de- delegation.

LONG-TERM SUPPORT SERVICES (LTSS)

CalOptima Health 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 nursing and sub-acute facility services for both adults and pediatrics. CalOptima Health's LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

HOME- AND COMMUNITY-BASED SERVICES:

CalOptima LTSS monitors member utilization, level of access and satisfaction with

Community Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization, when appropriate.

Behavioral Health Services

CalOptima Health offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional or behavioral functioning, Services include but are not limited to individual, family and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima Health also covers alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) provided to members 11 years and older, including pregnant women by providers within their scope of practice.

CalOptima Health 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 behavior 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.

CalOptima does not require members, or their practitioners undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at **855-877-3885**. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is used to make an initial determination of the member's impairment level due to a mental health condition. If the member has mild to moderate impairments, the member will be offered behavioral health providers within the CalOptima Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.

CalOptima Health directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

One Care (OC)
CalOptima Health offers the following mental health services to OC members:

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP) and partial hospitalization program (PHP)
- I Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing
- Opioid Treatment Program (OTP) services
- Electro Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS) through the OCMHP.

CalOptima Health directly manages all administrative functions of the OC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima Health 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 Health's state and federal contracts — and to CalOptima Health'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 services provided to members. The Board ensures 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 Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code
§54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the 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.

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

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care Representative
- Medi-Cal Beneficiaries
- Medical Safety Net Representative
- Orange County Health Care Agency (standing seat)
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent a broad provider community that serves CalOptima Health members. The PAC meets at least quarterly and is open to the public. The members include:

- Health networks
- Hospitals
- Physicians
- Nurse
- Allied health services
- Community health centers
- Health Care Agency (HCA)
- LTSS (LTC facilities and CBAS)
- 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 Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

Members of WCM FAC include-

- Family representatives:
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children representatives:
  - Community-based organizations; or
  - Consumer advocates

CalOptima Health Officers
Chief Medical Officer (CMO), Chairperson of the Utilization Management Committee (UMC), Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima Health's Chief Executive Officer (CEO) are the senior leaders 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 Health'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 Health'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, Care 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 Health'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 Health'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, Behavioral Health Integration (ED of BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED of BHI strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, Population Health Management (ED PHM) oversees the development and implementation of company wide Population Health Management strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* have primary assigned roles but may provide coverage and back up to other specialties as needed. All medical directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The medical director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health 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 uses 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. The medical director 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 biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIC.

- The medical director who oversees the behavioral health program is a participating member of the UMC, QIC and CPRC. The medical director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director supports the behavioral health aspects of the UM Program. The medical director also provides leadership and program development in the creation and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health 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.

- The medical director who oversees specialty programs and services is a key member of the medical management team and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM 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 Health's UM Program for CalOptima Health Community Network, CalOptima Health 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 Integration is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM operations. The director tracks, analyzes changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima Health in integrating physical and BH care services. This position provides leadership and direction to the BH UM team to ensure compliance with all local, state and federal regulations, that

accreditation standards are current, and all policies and procedures meet current requirements. This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, 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 for both physical and behavioral health (including onsite visits and process evaluation), 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 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. This position 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 agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position 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, Audit & Oversight oversees and conducts independent performance audits of CalOptima Health 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 Health policies, and industry best practices. The director ensures that CalOptima Health and subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is 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. The position interacts with the Board of Directors, CalOptima Health executives, departmental management, HN management and legal counsel.

UM Staffing Resources

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The following UM Program roles

- provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Manager, Utilization Management RN/LVN (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.

Supervisor, Utilization Management RN/LVN(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 Health 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.

Manager, Utilization Management RN/LVN (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health 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.

Supervisor, Utilization Management RN/LVN (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 Health 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.

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria, and is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient 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.

All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants are responsible for interacting with practitioners, members, family and other customers. Staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require clinical judgement be applied. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and medical directors.

Manager, Utilization Management (RN/LVN) (UM Monitoring) responsible for management of the day-to-day monitoring of UM activities, including monitoring of UM processes of Prior Authorization and Inpatient. Ensure that service standards are met, and operations are consistent with all regulatory requirements, accreditation standards and CalOptima Health policies and procedures.

Monitoring Nurses – UM (Clinical Auditors, LVN)) conducts routine oversight, monitoring and auditing of internal UM activities to ensure compliance with state, federal and accreditation standards. - Monitoring activities include prior authorization and inpatient file reviews, addressing Correction Action Plans (CAPS) findings, as well as identify opportunity for process improvement during the monitoring process.

Pharmacy Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health 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.

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 Health delegated health plans and CalOptima Health 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 Health, as well as national practice guidelines and on an ongoing basis, research, 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 interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

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 Health delegated health plans and CalOptima Health 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 Health, 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 Committee, interact frequently and independently with other department staff as needed to perform the duties of the position, and have frequent interactions with external contacts, including the pharmacy benefit managers' clinical department.

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.

LTSS Staffing Resources

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.

Manager, Long-Term Support Services (CBAS/LTC) develops and manages the LTSS department's work activities and team. The manager ensures that service standards are met, and operations are consistent with CalOptima Health's policies and regulatory and

accrediting agency requirements to ensure high quality and responsive services for CalOptima Health's members who are eligible for and/or receiving LTSS.

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.

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 qualified CalOptima Health members in LTC facilities and members receiving CBAS. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

Program Manager, Sr., LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department.

Behavioral Health Integration Staffing Resources

Manager, Behavioral Health CalOptima Health manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements.

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met.

Medical Case Managers (BH-RN/LVN or Licensed BH Clinician) provide inpatient and outpatient 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 psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Care Manager (BH) 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 BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions.

Qualifications and Training

CalOptima Health hires highly qualified clinical 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.

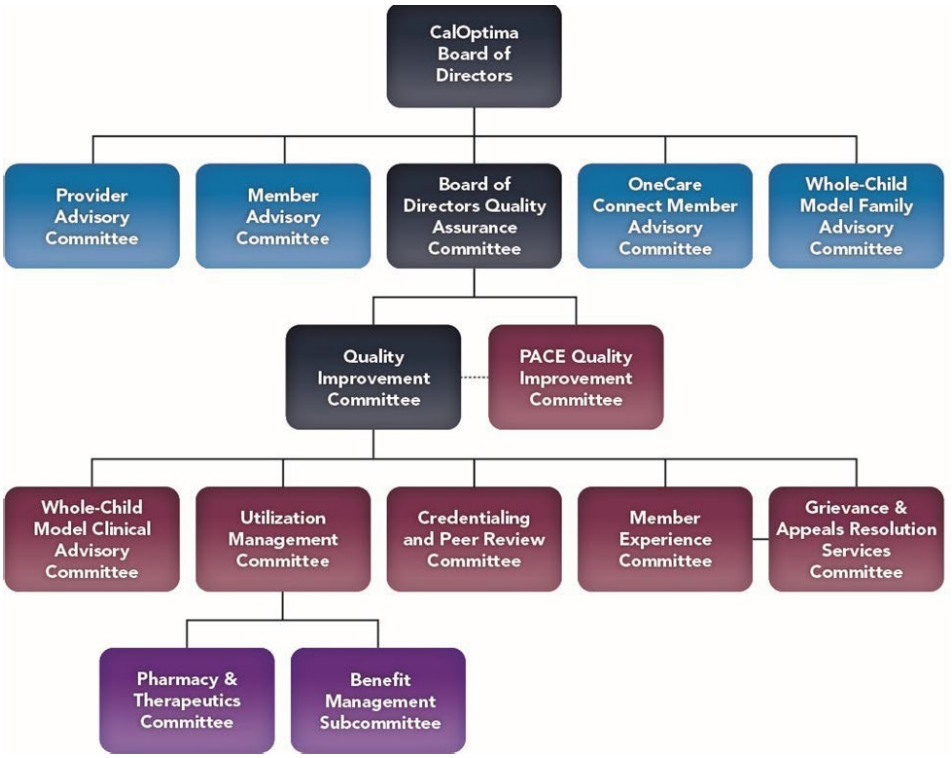
Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- Medical Management information system data entry
- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health.

CalOptima Health and its delegated HN UM staff 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.

2023 UM Committee (UMC) Committee Structure — Diagram



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 health care services by CalOptima Health 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.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy addressing the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

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 Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the department of compliance and assigned privacy officer. During the onboarding process, all CalOptima Health employees — including contracted professionals who have access to

confidential or member information — sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated 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:
    - Benefit Management Subcommittee (BMSC)
    - P&T Committee
- Reports to the QIC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- UM Workgroup
- LTSS

UMC Membership

Voting Members:

- CMO
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees Specialty Programs
- Medical Director who oversees Whole-Child Model Program
- 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:

- Executive Director, Behavioral Health Integration
- Director, UM
- 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 Health'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 Health'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 who oversees UM services— Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Behavioral Health Integration
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets quarterly, at minimum, 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, Executive Director of Behavioral Health Integration, 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 underutilization 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 uses 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 Health 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 Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima Health'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 Health 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

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' clinical needs, evaluating available services within the local delivery system and applying evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting. Covered services are those medically necessary health care services provided to members as outlined in CalOptima Health's contract with CMS and the State of California for Medi-Cal and OC. Medically necessarily means all covered services or supplies 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.
- Medical necessity for members receiving MLTSS is determined by using a member's current needs assessment and is consistent with person-centered planning.
- 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 Health UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary services are provided in the most appropriate setting. 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 Health's UM department is responsible for the review and authorization of health care services for CalOptima Health 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 review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied when reviewing prior authorizations, inpatient and outpatient concurrent review, and retrospective review requests:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- Evidenced based clinical criteria or guidelines are applied consistently,

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.
- Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, 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 Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- 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 Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service.
- OneCare members are notified in writing of any and all determinations.
- 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.

Supporting documents 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/ BMSC reviews the Prior Authorization List regularly, in conjunction with CalOptima Health'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 Health 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 Health 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 Health 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 Health'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 Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. The provider portal functionality includes referral intelligence rules, approved by clinical leadership to auto adjudicate when criteria is met. The referral intelligence rules and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up.
Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone.

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, CalOptima Health provides 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
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

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 a current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health 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 Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health 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 Health's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima Health 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 Health website.

The P&T Committee is responsible for development of the Medi-Cal physician-administered drug prior authorization list and the OneCare 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 January 1,2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medi-Cal/Medicare
CalOptima Health does not delegate OneCare 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, 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 Health's BHI department performs prior authorization review for BH 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 Health policy (approved by DHCS).

Medi-Cal/Medicare
CalOptima Health's BHI department performs prior authorization review functions for OC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, psychological testing, electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers.

Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima Health policies.

- The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may be made by a Medical Director or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health'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 timeframes 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 Health gives practitioners the opportunity to discuss BH UM denial decisions.

UM CRITERIA

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, 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: [RJ12]

Medi-Cal

1. Federal and State Law Mandates (i.e., Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
2. (e.g., MCG, National Comprehensive Cancer Network, etc.)
3. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)
4. Other: US Preventative Services Task Force, Guideline Central

5. CalOptima Health 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
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)
2. CMS Provider Manuals
    a. Internet-Only Manuals (IOMs) | CMS
3. Department of Health Care Services
4. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
5. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
6. CalOptima Health Policy and Procedures and/or Clinical Benefits and 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, as well as based on the member's individual needs. 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.

Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are used in conjunction with national guideline criteria in review for medical necessity. Additional guidelines may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

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 Health may be contacted, when necessary to avoid a conflict of interest. CalOptima Health 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 Health 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 Health'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 health website at www.CalOptima Health.org.

Inter-Rater Reliability (IRR)
At least annually, the CMO and Clinical Operations leadership assess the consistency with which Medical Directors and other clinical decision makers apply UM criteria in decision-making. The assessment is performed as an annual review to compare how reviewers' decision the same case. If an opportunity for improvement is identified through this process, UM and MD leadership takes corrective action. New UM staff are 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 Health 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. CalOptima Health has MD and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications includes directly speaking with practitioners and members, fax correspondence, electronic or telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff identify themselves by name, title and CalOptima Health 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 Health. In cases requiring immediate response the vendor staff notifies CalOptima Health on-call

nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM MD. A log is shared daily identifying activity and follow-up needed the following day.

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical 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 Health Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the Medical Director and requesting practitioner. All peer-to-peer discussions are documented within clinical documentation platform

UM Staff Access to Clinical Expertise

The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations and following sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities, utilize a Medical Director, or designee, as the sole 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, retrospective, inpatient 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 Health'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 Health's UM Program does not prohibit or restrict health care professionals from acting within the lawful scope of practice or advising or advocating on behalf of a member including but not limited to 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 Health 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 Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre- Service Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Notice must be postmarked within 2 business days of decision not to exceed 14 calendar days from receipt of the request.

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Routine (Non-urgent) Pre- Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of decision to defer, in writing, within 5 business days of receipt of information reasonably necessary to render a decision and no longer than 14 calendar days from the receipt of initial request. • 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.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. **Practitioner/Member:** Written Notice of Action "Delay" notification within 14 calendar days of receipt of the request for services.
	Additional information received	**Practitioner:**	**Practitioner: Electronic**

	• If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.	Within 24 hours of making the decision.	Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
	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.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

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Attachment A TIMELINES FOR MEDI-CAL

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** Written notice within 72 hours of the receipt of the request for services.

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Expediated Authorization (Pre-Service) - Extension Needed • Extension is extended when member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny, or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** Written notice within 72 hours of the receipt of the request for services.
	Additional information received • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision

	Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health 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 of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. Extension: CalOptima Health may extend the timeframe 48 hours of up to 14 calendar days under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 calendar days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 calendar days after the oral notification.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.

Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

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Attachment B TIMELINES FOR OneCare

OneCare Decisions and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.

Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	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 received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1. Explain that CalOptima Health 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. 4. Provide instructions about the expedited grievance process and its time frames.

Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health 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 of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medic al condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

Type of Request	Decision	Important Message (IM) from Medicare	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

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*Medi-Cal Pharmacy Prior Authorization Determination Timelines

*Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health and Magellan Rx

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.
Standard (Non-urgent) Preservice – Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS 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.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.

Expedited (Urgent) Preservice/Concurrent - Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS 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.
Post-Service/Retrospective	- A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.

Type of Request	Notification Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed - Additional clinical information not received within initial 14 calendar days.	- **Provider:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days. - **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Expedited (Urgent) Preservice/Concurrent - Delay Needed - Additional clinical information not received within initial 72 hours.	- **Provider:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days. - **Member:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days.
Post-Service/Retrospective	- **Provider:** Within 30 calendar days of receipt of the request. - **Member:** Within 30 calendar days of receipt of the request.

OneCare Pharmacy Part D Determination Timelines

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.

Type of Request	Notification Timeline (Member and Prescriber)
Standard (Non-urgent) Preservice/Concurrent	Within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Expedited (Urgent) Preservice/Concurrent	Within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Post-service/Retrospective	Within 14 calendar days of the initial receipt of the request.

Emergency Services

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 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.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health 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 hospital must notify CalOptima Health of a Post-Stabilization request for services prior to admission. Once a member is stabilized after emergency services but requires additional, medically necessary inpatient services The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) - apply to both contracted and noncontracted providers in CalOptima Health's Medi-Cal program. CalOptima Health or a HN shall approve or deny a prior authorization request for post-stabilization services if all information reasonably necessary to render a decision is received from a hospital within 30 minutes or 60 minutes for OC members. If CalOptima Health or the HN does not respond within the prescribed timeframe, medically necessary post-stabilization inpatient services are considered approved.

Retrospective Review

Retrospective review is an initial review of services that require prior authorization and have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for pre-service review. Retrospective Authorization is only permitted in accordance with CalOptima Health Policy and Procedure

GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which is as follows:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, or OneCare program, as applicable, at the time of service.

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 of 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/Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient admissions within 24 hours of admission. The inpatient review process assesses the clinical status of the member, verifies the need for continued hospitalization Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service being provided
- 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 requested
- Reasons for extension of the treatment or service

Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the members inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Inpatient 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 clinical criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager refers the case to the Medical Director for review. If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA) letter is issued immediately by fax and telephone to the attending physician, hospital and mailed to the member for OC members verbal notification is also provided.

The need for case management or discharge planning services is assessed during the admission review and each inpatient admission, focused on the most appropriate alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issue, the concern is referred to CalOptima Health QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, quality-driven treatment intervention for post-hospital care needs. It is a coordinated effort among the facility and CalOptima Health and includes but is not limited to attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, 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 multidisciplinary 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 Inpatient 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 Health 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 timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at a sixth grade reading 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 timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS 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 Health

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 Health has a comprehensive review system to address matters when Medi-Cal, OC 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 Health. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health'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 Health Member Complaint Policy. HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Appeal Process. These processes include but are not limited to:

- 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 all of CalOptima Health Networks except Kaiser are handled by CalOptima Health GARS. CalOptima Health works collaboratively with the community provider or delegated entity in gathering 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 Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The 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 Health 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 a confidential and peer protected process.

All members have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Health Customer Service department.

Expedited Appeals and Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome if not decisioned quickly, 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 regarding the expedited appeal criteria. Expedited appeals and grievances are managed in an accelerated fashion 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 Fair Hearing

CalOptima Health 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 Health and delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Fair 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 members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency or a comprehensive outpatient rehabilitation facility. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health 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 Health'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 , subacute care

Facilities are required to notify CalOptima Health of admissions within 21 days. Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes. 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, CalAIM or CBAS. Referrals to case management can also be made upon discharge when a member's needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff 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. A new benefit launched in October 2022 allow for members to receive Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

MSSP

CalOptima Health is an approved MSSP site through California Department of Aging (CDA).. The program provides services and support to help people 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.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM leadership team, the UM workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews the Over/Under Utilization report 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/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

Under and Over Utilization is tracked and monitored through the following areas and trends:

- ER visits per 1000
- Bed days per 1000
- Admits per 1000
- Average length of stay per 1000
- Readmission rates
- Pharmacy utilization measures
- Member grievances per 1000
- Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and 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 Deputy 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 Health provides an explanation of the GARS process, State 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 Health QI department for investigation and resolution.

Annually, CalOptima Health 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 areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern, which may include staff retraining and member/provider education.

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.
Program Updates and/or Changes

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Complex Case Management process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year.

Updates and/or changes to the CCM program and process include but are not limited to the following:

- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Provide targeted outreach and case management to support members who utilize primarily the emergency department for care and develop best practices for outreaching these members and improving their overall care.
- Continue development of specialized outreach and management for special populations, such as members struggling with homelessness, pain, or behavioral health issues. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.
- California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program went into effect in 2019.

- Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members.
- Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx.
- The OneCare Connect program ended effective December 31, 2022 and members transitioned to the OneCare (D-SNP) program effective January 1, 2023.
- Another component of CalAIM, Population Health Management was launched effective January 1, 2023 with a phased implementation.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The teams are multidisciplinary, and are composed of nurse Case Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and Member Liaison Specialists, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk Assessment Team, Health Network Liaison Team, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima mission and vision.

Director of Care Management directs all Case Management programs for CalOptima members to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for all departmental compliance with all local, state, and federal regulations and ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The incumbent works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and projects associated with the department to ensure compliance with department policies and procedures, along with the implementation of assigned projects. The incumbent may be required to attend joint operational and community meetings. The incumbent is responsible for monitoring of case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The incumbent will provide guidance to staff or will directly handle complex case management referrals. The incumbent will be accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The incumbent will serve as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager will facilitate communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Medical Case Manager (Oversight) is responsible for providing ongoing case management services for CalOptima members. The position facilitates communication and coordination among all participants of the health care team and the member to ensure that the services are provided to promote quality, cost-effective outcomes. The Oversight Case Manager completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to address medical, behavior, and psychosocial concerns. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.

Medical Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager or the Gerontology Resource Coordinator. The Medical Assistant performs medical and administrative routine tasks specific to the assigned unit, and office support functions. The Medical Assistant may also authorize requested services according to departmental guidelines.

Social Worker provides administrative case management and coordination of benefits for carved-out services. The Medical Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Medical Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinator support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCC will identify barriers to members' care and assist in in improving these barriers for all levels of care. The incumbent will work closely with the PCP and health care team to ensure member access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and

mailings, applying general business practices, as well as CalOptima policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects, and ensures that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the incumbent performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The incumbent interacts with other internal CalOptima departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Licensed Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

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

Each new employee is provided an 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 description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- Seniors and Persons with Disabilities Awareness Training
- OneCare Model of Care Training
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- QI Referral Process

CalOptima Health encourages and supports continuing education and training for

employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for each licensed CM employee. Licensed nursing staff is monitored for appropriate application of Review Criteria/Guidelines, NCQA requirements, and case management documentation. 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 Case Management staff on an annual basis. Delegated Health Network staff participates annually in CalOptima Health model of care training.

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 Health 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 Health. CalOptima Health 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, continuity of care may also be explored to continue treatment with the provider in certain situations. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health or a member terminates from CalOptima Health to a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk stratification process or Predictive Modeling Tool
- Health Information Form (HIF) or Member Evaluation Tool (MET), if available

The avenues for referring a member for case management are:

- Member self-referral
- Member's authorized representative/family referral

- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN/SRG/PMG referral
- Utilization Management referral
- Long Term Services and Supports referral

The case management program includes:

- Documented process to assess the needs of member population.
- Development of the program through use of evidenced based guidelines.
- Defined program goals.
- Standardized mechanisms for member identification through use of data.
- Multiple avenues for referrals to case management.
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings.
- Process to inform eligible members of case management services, and the ability to elect or decline services.
- Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.
- Use of evidenced-based clinical practice guidelines or algorithms.
- Initial assessment and ongoing management process.
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.
- Developing prioritized goals that consider the member or caregiver's goals and preferences.
- Developing member self-management plans.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to ensure quality, timeliness, and effectiveness of services.
- Analyzing data and member feedback to identify opportunities for improvement.
- Mechanism for identification and referral of quality-of-care issues to QI Department.
- Coordination of carved out services, such as Denti-Cal
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of member's health care status and needs, including condition-specific issues:

- Member's right to accept or decline case management services
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Evaluation of behavioral health, cognitive function, and substance use disorder
- Evaluation of cultural and linguistic needs, preferences or limitations
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, preferences or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)

- Assessment of social drivers of health (SDOH)
- Review current status and treatment plan
- Identifies barriers to quality, cost-effective care and fulfilling the treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Evidence-based clinical guidelines or algorithms to conduct assessment and management

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan that identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes the following:

- Development of prioritized SMART goals that take into account:
- Member or caregiver's goals or preferences
- Member or caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with self-management plan
- Scheduled time frame for follow-up and communication with members
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfer
- Collaborative approaches to be used, including family/caregiver participation

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The Case Management Department assists 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.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services
- California Children's Services (CCS)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver (formerly NF/AH Waiver)
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)

- Tuberculosis Program (Direct Observation Therapy)
- Collaborate with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Members with end stage renal disease (ESRD) and a comorbid condition of prostate cancer may not meet criteria for transplant based on guidelines. Lack of transportation may create obstacles to care, yet the member may not meet criteria for non-emergency medical transportation. Members who are at the end-of-life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member's preferences.
- PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the member, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the member's treatment plan

- Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan
- Identification of the need for medical, specialty or ancillary referrals
- Referrals to case management and/or disease management

Complex Case Management

Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:

1. Basic Case Management Services
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optima health or improved functionality
4. With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually

Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

The members in Complex Case Management usually:

1. Are at high risk; or
2. Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:
3. Spinal Injuries
4. Transplants
5. Cancer
6. Serious Trauma
7. AIDS
8. Multiple chronic illnesses
9. Chronic illnesses that result in high utilization
10. Have a complex social situation that affects the medical management of their care; or
11. Require extensive use of resources; or
12. Have an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima uses this criteria when data mining and as a guideline for internal and external referral sources to identify appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal

abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.

Case Management staff ensures coordination of care with other entities that provide services for Children with Special Health Care Needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

The goals of CSHCN Case Management are to:

- Collaborate with family and providers to develop an Individualized Care Plan
- Facilitate member access to needed services and resources
- Prevent duplication of services
- Optimize member's physical and emotional health and well-being
- Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) children and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.

The Whole Child Model program includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results

Transitional Care Services (TCS)

Transitional Care Services (TCS) are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facility. For members enrolled with Case Management, Case Managers will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

The Case Manager is responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The Case Manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the Case Manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.

Special Programs

Transplant Program
The CalOptima Health 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 or CMS certified Centers for OneCare. Case Management will follow the member and assist as needed through the transplant evaluation process, while they are waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed the transplant continuum. 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 Health monitors and maintains oversight of the Transplant Program and report to UM Committee to oversee the accessibility, timeliness, and quality of the transplant protocols.

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Annual Review:
2022 UM Program Evaluation and 2023 UM/CM Integrated Program Description

Kelly Giardina, MSG, CCM Executive Director Clinical Operations

Stacie Oakley, RN Director Utilization Management

Our Mission

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

Our Vision

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

Utilization Management (UM) Program Description and Program Evaluation

- CalOptima Health annually evaluates the effectiveness of the UM program:
  - Program Structure
  - Responsibility for the UM program
  - Significant changes, new initiatives and programs
  - Program Scope and processes used to determine coverage and medical necessity
- Program description is revised based on evaluation and updated for the following year

- The 2022 Program Evaluation and 2023 Integrated UM and CM program description approved by Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC).

2022 UM Program Evaluation
Q4’2021-Q3’2022

Kelly Giardina, MSG CCM
Executive Director, Clinical Operations

2022 UM Program Evaluation

- Utilization Management Program Evaluation (Q4 ‘21- Q3 22)

  - **Q4’2021-Q1’22- backlog**: Short- and long-term accomplishments and interventions to mitigate further occurrences
    - Daily PA and inventory management protocols
    - Turnaround time monitoring (all layers of leadership)
    - Staff education and Inter-Rater Reliability (IRR) testing
    - Enhanced staff coaching with an added Clinical Trainer
    - Weekend non-clinical, Nursing and MD coverage
    - Command Center Monitoring for timely notification of determinations

2022 UM Program Evaluation

- Medical Directors responsibilities and capacity expanded:
  - Chairing of Utilization Management Work Group/Benefit Management Subcommittee
  - Internal Clinical and external provider education
  - Additional Medical Director Specialties (Transplant, Internal/Preventative Medicine and Family Practice)
  - Facility Rounding Weekly (complex discharge, outlier cases, peer-to-peer)

- Behavioral Health enhanced role in the development and oversight of the UM Program

2022 UM Program Evaluation

- 90 Day Emergency Department Pilot Program
  - CalOptima Health Prior-Authorization hybrid nurse embedded into the Emergency Department at St. Joseph Hospital
  - October through December 2022
  - **Pilot Goals**
    - Promote ED communication and member access to Prior authorization, specialty care across all CalOptima Networks
    - Increase CalAIM Community Supports / ECM Referrals
    - Increase PCP follow up visit within 30 days of ED visit
    - Decrease high inappropriate Emergency Department Utilization

2022 UM Program Evaluation

- 90 Day Emergency Department Pilot Program (con't)
  - Outcomes, successes, results and next steps
    - 72% of the members initially identified as high utilizers of ED services were successfully connected with ambulatory care and CalAIM ECM/ CS after pilot interventions

    - 190 members were seen as a part of the pilot program for the following successful interventions in real time:
      - PCP Appointments scheduled 16%
      - Specialty Appointments scheduled 11%
      - Other Case Management Referrals 4%
      - Prior Auth Referrals completed 9%
      - Transportation issues resolved 3%
      - Medication Issues resolved 8%
      - Community Support Referrals 13%

2022 UM Program Evaluation

90 Day Emergency Department Pilot Program (con't)

- Next steps:
  - Additional pilot analysis including claims review
  - Explore automation for specific and targeted services based on analysis and MD review
  - Continue program through real time remote communication (Teams channel, telephonic secure email)
  - Identify future opportunities programmatic and remote support to leverage economies of scale

2022 UM Program Evaluation

Summary Inpatient Utilization and ED					
Metric	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
ALOS	4.3	5.09	5.30	5.31	4.82
Admit PTMPY	284	120.4	114.2	116.6	126.0
Days PTMPY	358	613.1	605.4	619.5	607.1
Readmit %	25%	16.73%	15.96%	15.26%	16.79%

•2022 Performance Goals – MediCal roll up (excludes WCM and HN data)

Emergency Department Utilization by Aid Code line of business				
Line of Business	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
MediCal Expansion	489.6	483.6	511.6	529.9
TANF 18+	523.3	558.4	520.7	580.3
TANF <18	355.7	342.9	368.8	375.1.
SPD	772.6	700.1	688	748.3
LTC	480.9	487.4	385.7	386.2
WCM	519.7	491.2	278.1	293.2

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2022 UM Program Evaluation

Inpatient Utilization Details by Metric and Aid Category

ALOS					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	4.3	3.67 ↓	4.21 ↓	4.22 ↓	3.71 ↓
TANF <18	4.3	3.59 ↓	3.43 ↓	2.72 ↓	3.08 ↓
SPD	4.3	7.40 ↑	6.26 ↑	6.67 ↑	6.43 ↑
Long Term Care (LTC)	4.3	8.33 ↑	9.65 ↑	6.09 ↑	8.21 ↑
Whole Child Model	4.3	6.45 ↑	6.09 ↑	8.14 ↑	7.09 ↑

Admit PTMPY					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	284	165.3 ↓	158.0 ↓	160.2 ↓	188.4 ↓
TANF <18	284	12.2 ↓	11.9 ↓	10.1 ↓	11.4 ↓
SPD	284	281.5 ↓	273.6 ↓	257.8 ↓	265.7 ↓
Long Term Care (LTC)	284	786.9 ↑	753.2 ↑	457.1 ↑	692.6 ↑
Whole Child Model	284	219.9 ↓	208.1 ↓	113.9 ↓	120.3 ↓

2022 UM Program Evaluation

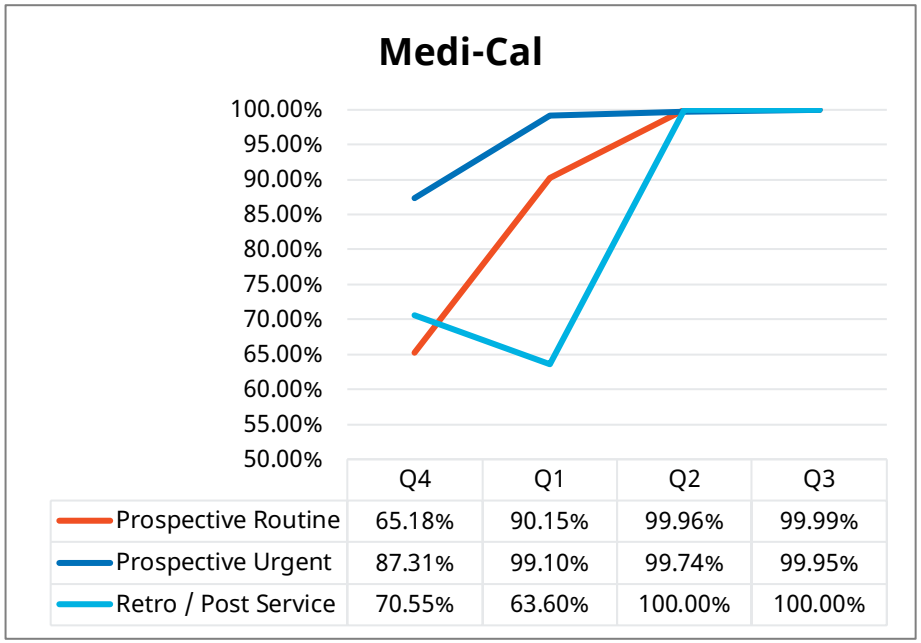
Inpatient Utilization Details by Metric and Aid Category

Days PTMPY					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	**358**	606.7 ↑	665.8 ↑	676.7 ↑	698.4 ↑
TANF <18	**358**	43.6 ↓	40.7 ↓	27.5 ↓	35.0 ↓
SPD	**358**	2,083.9 ↑	1,711.9 ↑	1,720.3 ↑	1,710.0 ↑
Long Term Care (LTC)	**358**	6,557.40 ↑	7,266.50 ↑	2,785.70 ↑	5,687.00 ↑
Whole Child Model	**358**	1,417.9 ↑	1,268.3 ↑	926.5 ↑	853.4 ↑

Readmit %					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	**25%**	12.38% ↓	13.44% ↓	11.98% ↓	11.83% ↓
TANF <18	**25%**	0.00%	0.00%	0.00%	0.00%
SPD	**25%**	19.13% ↓	19.38% ↓	17.70% ↓	21.80% ↓
Long Term Care (LTC)	**25%**	27.91% ↑	16.22% ↓	11.11% ↓	32.56% ↑
Whole Child Model	**25%**	11.06% ↓	7.63% ↓	8.50% ↓	4.33% ↓

2022 UM Program Evaluation

Prior Authorization Turnaround Time Compliance

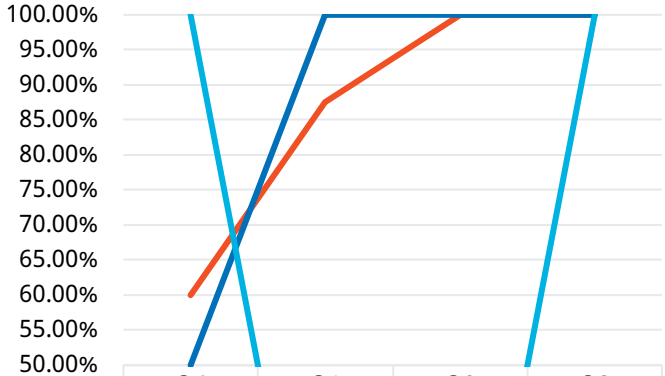


	Q4	Q1	Q2	Q3
Prospective Routine	65.18%	90.15%	99.96%	99.99%
Prospective Urgent	87.31%	99.10%	99.74%	99.95%
Retro / Post Service	70.55%	63.60%	100.00%	100.00%

2022 UM Program Evaluation

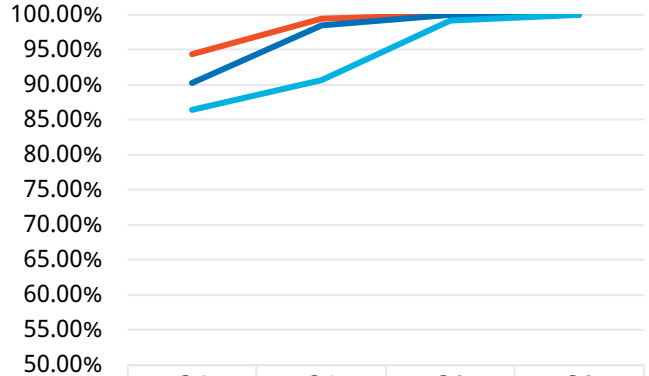
Prior Authorization Turnaround Time Compliance

OneCare



	Q4	Q1	Q2	Q3
Prospective Routine	60.00%	87.50%	100.00%	100.00%
Prospective Urgent	50.00%	100.00%	100.00%	100.00%
Retro / Post Service	100.00%	0	0	100.00%

OneCare Connect



	Q4	Q1	Q2	Q3
Prospective Routine	94.41%	99.43%	99.94%	100.00%
Prospective Urgent	90.32%	98.44%	100.00%	100.00%
Retro / Post Service	86.36%	90.65%	99.24%	100.00%

2022 UM Program Evaluation

Referrals Processed

Referrals Processed Q4 2021 - Q3 2022					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2021	**Qtr4**	Medi-Cal	**37,414**	**6,256**	**421**
		OneCare	5	2	2
		OneCare Connect	1,878	341	154
2022	**Qtr1**	Medi-Cal	44,678	5,857	684
		OneCare	8	4	-
		OneCare Connect	1,936	320	107
	Qtr2	Medi-Cal	47,626	7,682	1,180
		OneCare	9	2	-
		OneCare Connect	1,543	304	131
	Qtr3	Medi-Cal	42,298	8,359	611
		OneCare	11	2	2
		OneCare Connect	2,146	346	121
Grand Total			**179,552**	**29,475**	**3,413**

Referrals Received Q4 2021 - Q3 2022	
Faxes	251,346
COLAS	198,728
• COLAS Auto Approved	75,136
Total	450,074

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2022 UM Program Evaluation

Pharmacy Utilization

- Retail Pharmacy: $PMPM costs for CY22 are below expected spend for OneCare and above expected spend for OneCare Connect.
  - OneCare Connect drug cost increases are primarily driven by increased utilization of brand diabetes and chemotherapy medications.
- Goals were met for two of the three adherence measures. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

Measure	Medication Adherence for Diabetes Medications	Medication Adherence for Hypertension (RAS antagonists)	Medication Adherence for Cholesterol (Statins)
Rate	87%	89%	88%
Goal	88%	89%	88%

•2022 Performance Goals – MediCal roll up (excludes WCM and HN data)

2022 UM Program Evaluation

Inter-Rater Reliability

- All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	96%
UM Clinical Staff: Concurrent Review	96%
Physicians	99%
Pharmacy	94%
LTSS: LTC	97%
LTSS: CBAS	97%
LTSS: MSSP	97%
Behavioral Health	98%

2022 UM Program Evaluation

Member and Provider Satisfaction

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, and responses from the CAHPS survey, related to the UM Program.

- Member feedback obtained through Grievances and Appeals
  - Access to Providers/Specialist
    - Provider no longer contracted
    - Provider panel closed
    - Provider limitations due to type of required care for member, member age, or existing-affiliation requirements

2022 UM Program Evaluation

Member and Provider Satisfaction (con't)

- Member feedback obtained through 2022 CAHPS
  - Timeliness of specialist appointments
    - 71.3% of adult members and 73.0% of child members usually or always got an appointment with a specialist as soon as needed, with a decrease from 81.4% from the previous survey for adult members.
  - Access to care, tests, and treatment
    - 80.8% of child members felt it was usually or always easy to get the care, tests, or treatment child needed, with a decrease from 85.6% from the previous survey.
- In 2022, there were a total of 27 Potential Quality Issues (PQIs) related to the UM Program:

Potential Quality Issues (PQIs)					
	Q1	Q2	Q3	Q4	TOTAL
Authorization Denied or Delayed	0	5	9	13	27

2022 UM Program Evaluation

Member and Provider Satisfaction (con't)

- Provider feedback from the CalOptima Health Provider Satisfaction survey 2022
  - Review of UM Program Experience

55% of providers reported being satisfied or very satisfied with the UM Program experience, with further examples citing

- Rapid response to questions
- Access to direct referrals
- Timely processing of treatment requests

10% of providers reported being somewhat dissatisfied or very dissatisfied with the UM Program Experience, with examples citing.

- Challenges with the Authorization Dept processing retro-authorization requests for Private Duty Nursing
- Denial policy is not in guide with standards of care

Questions?

Integrated UM and CM Program Description

Stacie Oakley, RN
Director, Utilization Management

2023 Integrated UM and CM Program Description Updates

- Newly Integrated Utilization Management and Case Management program description.
  - Includes Quality, Pharmacy, Population Health and Behavioral Health initiatives and care delivery

  Quality Program:
  - Goals:
    - Comprehensive Health Equity framework
    - Further enhance and improve quality of care and member experience
  - Initiatives:
    - Comprehensive Community Cancer Screening and Support
    - Five-Year Hospital Quality Program

2023 Integrated UM and CM Program Description Updates

- Clinical Pharmacy updates
  - Transition to new model for MediCal Magellan Rx
  - CalOptima Health continues to manage the pharmacy benefits for OneCare and PACE
  - Turn-around timetables updated

- Population Health Management (PHM) Program Framework
  - PHM approach includes the following:
    - Gathering Member Information/ feedback
    - Understanding Risk
    - Implementing Services and Supports

2023 Integrated UM and CM Program Description Updates

- Population Health Management (PHM) Program framework (con't)
- Goals of programs;
  - Trust and meaningful engagement with members
  - Data-driven risk stratification and predictive analytics to address gaps in care
  - Revisions to standardize assessment processes
  - Care management services for all high-risk members
  - Robust transitional care services (TCS)
  - Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
  - Interventions to support health and wellness for all members

2023 Integrated UM and CM Program Description Updates

- Utilization Management 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 Health members, including but not limited to:
    - Coordination of care across CalOptima Health programs to improve member outcomes
    - Protecting confidentiality of members
    - Identify staffing needs, including Medical directors
    - Provide continuous training and mentoring for UM staff
    - Clearly define roles and responsibilities for UM activities
    - Promote a high level of member and provider satisfaction

2023 Integrated UM and CM Program Description Updates

- CalAIM Goals
  - Utilize the Whole Person model to identify the most vulnerable members
  - Improve outcomes through value-based initiatives
  - Develop seamless and consistent delivery of care

- Case Management Program Goals include but are not limited to:
  - Establishment of multiple referral methods (No wrong door)
  - Increased member awareness of Case Management services
  - Collaboration with UM on early identification of members
  - Development data driven methods of identifying members
  - Early identification of members educational needs and referrals to Population Health

2023 Integrated UM and CM Program Description Updates

- UMC Updates
  - Behavioral Health clinician advisor with UMC voting Membership
  - Review and update automation and Prior Authorization list process to include work group discussion, BMSC and UMC
  - Updated the functionality and description of the provider portal and automation
  - Highlighted and refinement of requirements for retrospective request for services.

2023 Integrated UM and CM Program Description Updates

- Behavioral Health
  - Highlighted Behavioral Health's integration throughout the UM Process and care delivery system
- CBAS
  - Benefit continued to receive Emergency Remote Services in lieu of attending the center

- Reviewed standards related to the Program Description to ensure programmatic and care delivery alignment. (UM1A, 2A and 4B)

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 14, 2023
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

4. Recommend Board of Directors Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

The Whole-Child Model Family Advisory Committee recommends:

1. Reappointment of the following individuals to each serve two-year terms on the Whole-Child Family Advisory Committee, effective upon Board approval:
    a. Monica Maier as an Authorized Family Member Representative for a term ending June 30, 2025; and
    b. Lori Sato as an Authorized Family Member Representative for a term ending June 30, 2025.

2. New appointment of the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board approval:
    a. Cally Johnson as an Authorized Family Member Representative for a term ending June 30, 2025;
    b. Jennifer Heavner as an Authorized Family Member Representative for a term ending June 30, 2025;
    c. Sofia Martinez as a Community Based Organization Representative for a term ending June 30, 2025; and
    d. Janis Price as a Consumer Advocate Representative for a term ending June 30, 2025

3. Reappoint Kristen Rogers an Authorized Family Member as the Committee Chair through June 30, 2024.

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model (WCM), incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County-Organized Health System plans. A provision of the WCM program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Health Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Health Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, nine of whom are designated as family representatives and two of whom are designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as community

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seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill the nine designated seats.

Discussion

CalOptima Health conducted comprehensive outreach, including sending notifications to community-based organizations, conducting targeted community outreach to agencies and community-based organizations serving the various open positions, and posting recruitment materials on the CalOptima Health website as well as CalOptima Health's social media sites, such as LinkedIn and Facebook.

With the fiscal year ending on June 30, 2023, five WCM FAC seats will expire: three Authorized Family Member Representatives and two Community Based Organization/Consumer Advocate Representatives. In addition to the five expiring seats, there is one open seat for an Authorized Family Member Representative and one seat for a Consumer Advocate Representative on the committee, for a total of six seats available for appointments.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC committee members Chair Kristen Rogers and Members Maura Byron and Erika Jewell, evaluated each of the applicants for the current openings. The WCM FAC Nominations Ad Hoc Subcommittee proposes the slate of candidates for the six vacancies and forwards the recommended slate of candidates for final consideration at the June 14, 2023 Quality Assurance Committee for appointment by the Board of Directors at its August 3, 2023 meeting.

The candidates for the open positions are as follows:

Authorized Family Member Representative

Monica Maier (Reappointment)

Monica Maier is the stepmother and main caregiver of a child who receives CCS services. Ms. Maier continues to advocate on behalf of parents and their children with CCS conditions. She has been a member of the WCM FAC since February 2020.

Lori Sato (Reappointment)

Lori Sato is the mother of a special needs child who currently receives CCS and Medi-Cal services. Ms. Sato has learned to navigate new systems to better advocate for children with special needs. She is familiar with medical therapy units for various therapies (physical and occupational) and for special equipment needs by CCS children. Ms. Sato has been inspired by other parents who are knowledgeable about the system to help CCS children get the care they need. Ms. Sato has been a member on the committee since July 2022, and she is currently serving the remainder of a term on the WCM FAC.

Cally Johnson (New Appointment)

Cally Johnson is the mother of a special needs child. Ms. Johnson has several years of experience working with the Autism Speaks foundation and as a long-term care ombudsman. Ms. Johnson has over 20 years of experience as a private tutor for children in grades K-12 with special needs. Ms. Johnson's

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knowledge of CCS places her in a unique perspective to assist families of children with special needs with her bilingual skills.

Jennifer Heavener (New Appointment)
Jennifer Heavener has been navigating the Medi-Cal and CCS world for the past 20 years with her special needs child, who is a high consumer of medical services. Her experience as an advocate and caregiver gives her a unique perspective that will help other families with transition through the WCM program.

Community-Based Organization Representative

Sofia Martinez, LCSW (New Appointment)
Sofia Martinez is the Chief Executive Officer of Reimagine, a community-based organization which offers an array of specialized therapies. Ms. Martinez is a Licensed Clinical Social Worker with two decades of experience working with children and adults with developmental disabilities. Prior to becoming the Chief Executive Officer of Reimagine, Ms. Martinez led the Children's Services programs at both the Orange and Fullerton campuses. She brings her longtime management and direct experience working with children with disabilities in a community that knows her well to the WCM.

Consumer Advocate Representative

Janis Price (New Appointment)
Janis Price is a certified educator with the Orange County Department of Education serving as Coordinator of Family and Community Engagement where she works directly with families who are Medi-Cal beneficiaries. She assists families by connecting them to community outreach services. She is committed to helping every family in Orange County be empowered to know their rights and opportunities available to partner with their schools to help in their whole child's success. Her knowledge of the diverse yet detailed school system, combined with her heart for the family, offers a safe place for questions, answers, and a renewed love for schools, students, families and their communities. Ms. Price currently participates on several advisory boards to help develop comprehensive plans for prevention, homelessness and foster youth, academic success and county-wide adverse childhood experiences and equity workgroups.

Committee Chair
Kristen Rogers
Ms. Rogers is the parent of a CalOptima Health member and CCS beneficiary. She is an active volunteer at Children's Health of Orange County and has served on the WCM FAC since 2018. In March of 2019, Ms. Rogers was appointed to the state CCS Advisory Group as a representative of CalOptima Health and the WCM FAC.

Fiscal Impact
Each authorized family member representative appointed to the WCM FAC may receive a stipend of up to $50 per committee meeting attended. Funding for the stipends is a budgeted item in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

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Rationale for Recommendation

As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancies on the committee. The WCM FAC Nominations Ad Hoc Subcommittee forwards the recommended candidates to the Board of Directors' Quality Assurance Committee for consideration and recommendation to the Board of Directors.

Concurrence

Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *06/08/2023*
Authorized Signature **Date**

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CalOptima Health

Update on Assessment of Quality

Quality Assurance Committee Meeting
June 14, 2023

Our Mission

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

Our Vision

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

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Agenda

- Medicare Star Rating
- Member Experience Improvement Activities
- Credentialing Assessment

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Medicare Star Rating

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OneCare Star Ratings

Star Rating	CY2022	CY2023
Part C	3.5	**2.5** ↓
Part D	4.5	3.5 ↓
Overall	4	3 ↓

- Decreases in both Part C and Part D star ratings are driven by decreases in member satisfaction scores

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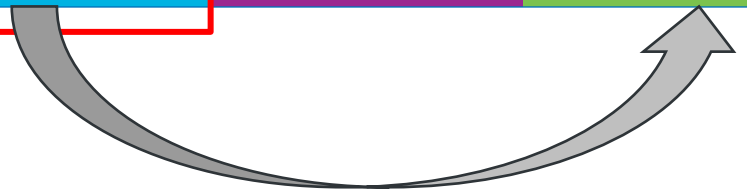
Star Rating Timeline

	2021	2022	2023	2024	2025	2026
	Measurement Year	Reporting Year	Star Rating Year **Part C 2.5** Part D 3.5 Overall 3	Bonus Payment Year		
		Measurement Year	Reporting Year	Star Rating Year **Projected Overall 2.5**	Bonus Payment Year	
			Measurement Year *	Reporting Year	Star Rating Year	Bonus Payment Year



- We are in the 2023 measurement year which is the time period for implementing improvement initiatives to impact 2025 star ratings.

The measurement period for next year's star ratings (2024) is completed.

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Member Experience Improvement Activities

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Improving Member Experience

Vision	*By 2024, provide CalOptima Health members with optimal member experience during interactions with providers and the health plan ensuring that members get the care that they need.*
Core Strategy	*Collaborative partnership with Health Networks, providers, and CalOptima Health in support of improving member experience and improving star ratings through system enhancements.*

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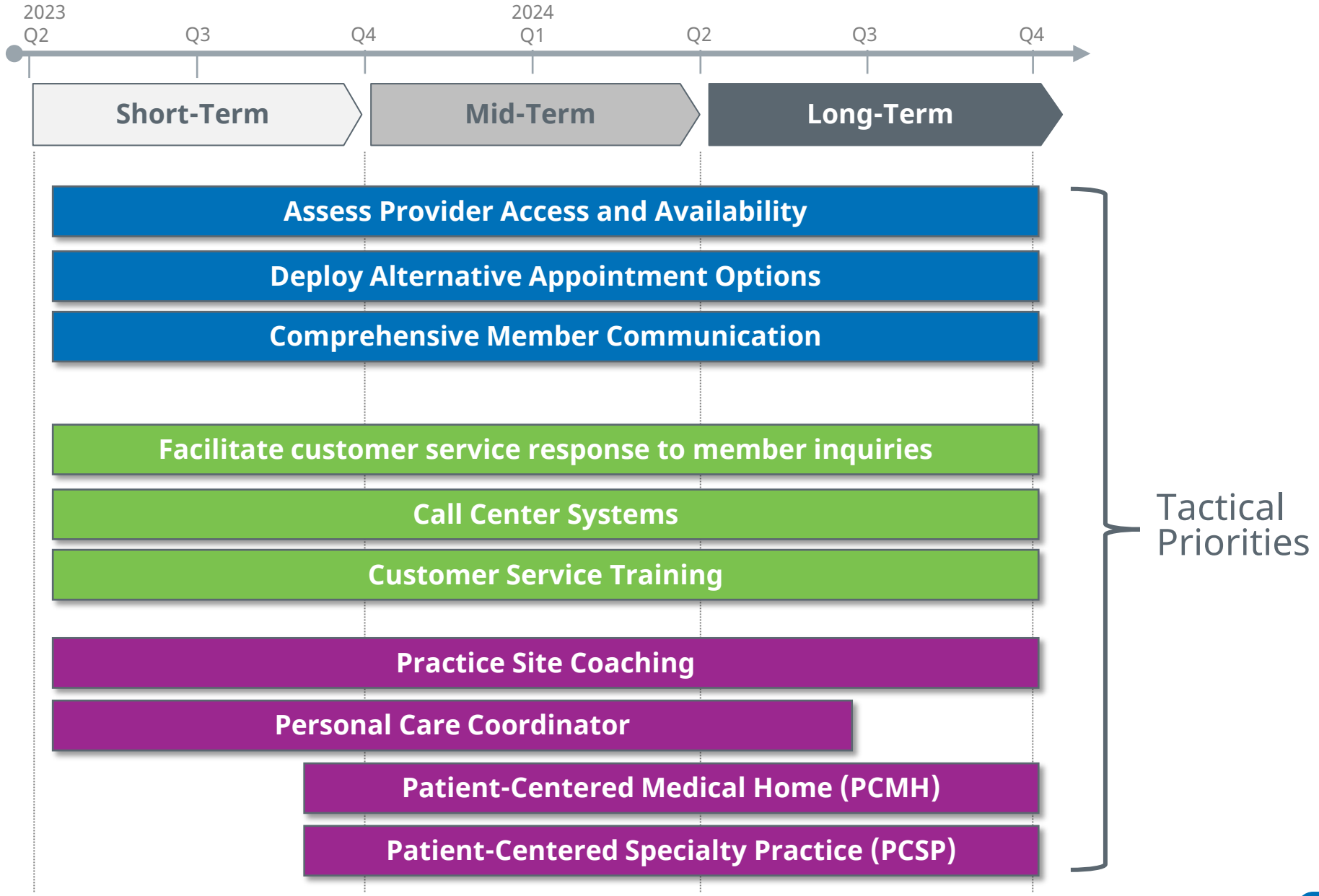
Strategic Priorities



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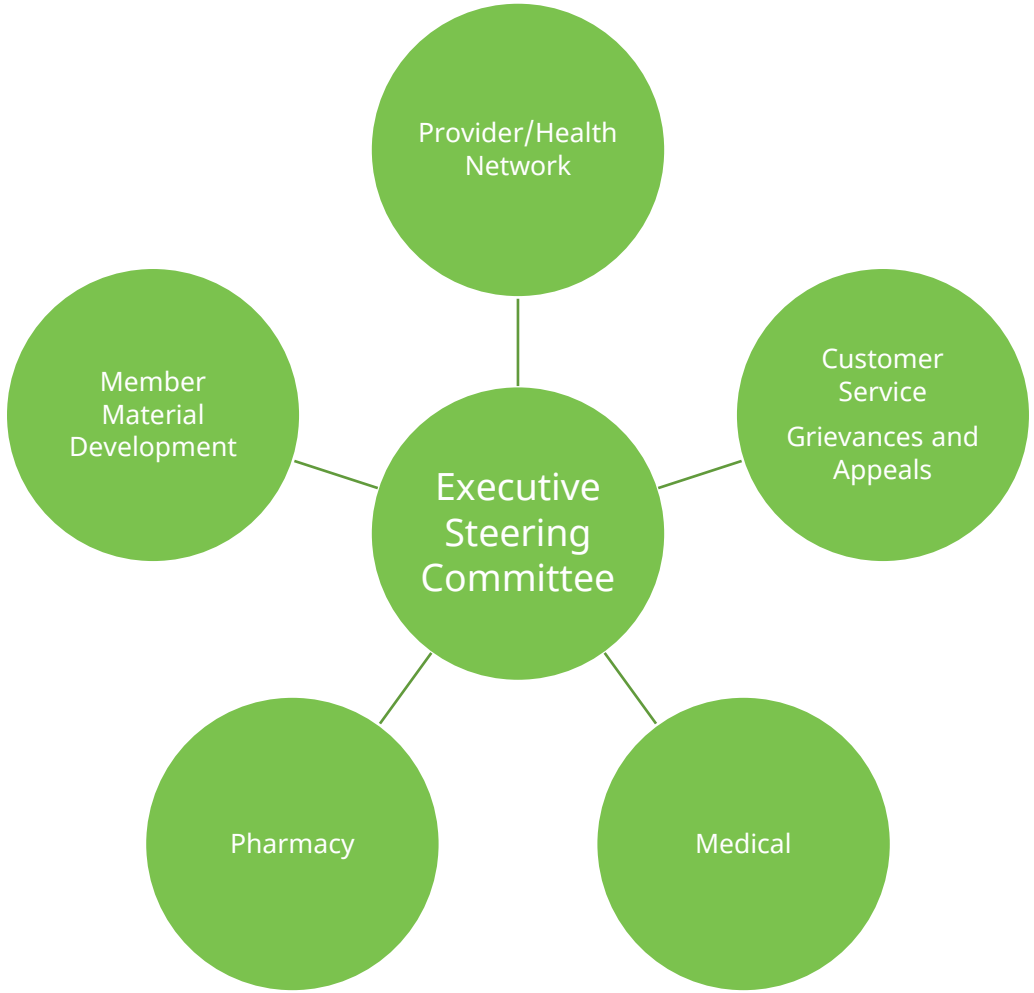
Implementation Work Groups



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Key Accomplishments Q2 2023

Improving Access to Care	Improving Customer Service	Improving Provider Office Efficiency
• Reviewed Provider Portal to identify opportunities to improve Provider Authorization Submissions to expeditiously identify appropriate specialists (orthopedics and general surgery) • Advertise Nurse Advice Line in OneCare Spring Newsletter, website, and to providers • Promote MedImpact member portal in OneCare Spring newsletter so members can manage their budget and health • Promote Improving Medication Adherence in OneCare Spring newsletter • Initiate coaching of top prescribers with low percent of extended day supply maintenance prescriptions • Prepare Health Network data reports highlighting deficiencies related to Provider to Member ratios, timely access standards, and time/distance standards • Prepare Health Network data reports showing frequency of Out of Network provider requests • Prepare Health Network report for grievances related to provider access and quality of service issues	• Implement new process for situations when a Member is at Pharmacy and transfer to CalOptima Health Pharmacy team to assist at point of care and minimize Member call back • Update desk top procedure for Customer Service Supervisors and Leads to access Optum Portal to view Member authorization status, during Member call and as needed • Create concept for pilot program for a specialized Customer Service team and engage cross-functional areas to focus on assisting high Member calls and address needs	• Created scope of work for consultant to conduct practice site coaching with identified high volume provider offices • Initiate coaching of top prescribers with low percent of electronic prescriptions to move from paper to electronic prescription orders • Updated personal care coordinator contact list to include 1st, 2nd and a 3rd individual contacts to work with customer service representative to assist Members during call

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Credentialing Assessment

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Credentialing Assessment Status Update

Status	Actions	Timeline
Completed	• Kick-Off Meeting with consulting and credentialing teams • Confirm project workplan, timeline and stakeholders • Set up secure file transfer protocol • Documentation/data request submission	• April 2023 • April 2023 • April 2023 • May 2023
In-Progress	• Document review by consultants • Interviews with key credentialing staff and stakeholders	• May-June 2023 • May- June 2023
Next Steps	• Identifying gaps and risks • Report outlining current strengths and future data opportunities	• June 2023 • July 2023

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National Committee for Quality Assurance (NCQA) Health Plan Accreditation Update

Quality Assurance Committee Meeting

June 14, 2023

Our Mission

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

Our Vision

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

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Why National Committee Quality Assurance (NCQA)?

- NCQA standards are a roadmap for improvement—organizations use them to perform gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. Standards evaluate organizations on:
  - Quality Management and Improvement.
  - Population Health Management.
  - Network Management.
  - Utilization Management.
  - Credentialing and Recredentialing.
  - Member Experience.
- Department Health Care Services DHCS) will require all MCPs and their subcontractors (delegated entities) to be NCQA accredited by 2025.
- We are currently Accredited for Health Plan Accreditation since 2012.

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HP Accreditation Scope and Scoring

- Health Plan Accreditation includes document and file review in 6 core categories.
  - Quality Management and Improvement (QI) (18 Points)
  - Population Health Management (PHM) (22 Points)
  - Network Management (NET) (29 Points)
  - Utilization Management (UM) (49 Points)
  - Credentialing and Recredentialing (CR) (17 Points)
  - Member Experience (ME) (26 Points)
- To earn Accreditation, plans must Meet at least 80% of applicable points in each standards category and submit HEDIS/CAHPS annually. Submit HEDIS/CAHPS annually thereafter.
- Less than 80% applicable points on any category: The plan earns **Provisional status**.
- Less than 55% of applicable points: The organization can be denied accreditation.

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CalOptima Health

Health Plan (HP) Renewal Accreditation

- CalOptima Health's NCQA health plan accreditation journey started 13 years ago in 2010.*
- Renewed accreditation in 2015, 2018 and 2021
- In 2021 we were awarded "Accredited" status on our Medicaid-HMO, scoring 100% on HP Standards.
- CalOptima Health is currently in the two-year survey look-back period which began 4/30/2022.
- Re-accreditation submission is scheduled for April 30, 2024.
- Virtual File Review on June 17-18, 2024

**CalOptima Health achieved initial accreditation in 2012, scoring 100% on Standards*

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CalOptima Health

NCQA Current Standing

- 90% of all Documents needed for Year One 4/30/2022-4/30/2023, received and approved. Remaining documents are being finalized to ensure full compliance.
- Completed File Review Mock Sessions with NCQA Consultants:
  - Complex Care Management (CCM) Health Networks **(3/27/23)**
  - CCM CalOptima Heath Staff **(3/29/23)**
  - Credentialing with Credentialing only Health Networks **(4/26/2023)**
  - Appeals CCN **(5/2/2023)**
  - Credentialing Health Networks **(5/3/2023)**
  - Credentialing CCN **(5/4/2023)**
  - UM Medical Denials Health Networks **(5/8/2023)**
  - UM Medical Denials CCN **(5/10/2023)**
- We will prepare all documents and reports for Year 2 (4/30/2023-4/30/2024) and 24-month documents needed to meet 24-month survey period.
- Submit Application and fees for Renewal Survey by July 2023
- Give status update to executive team, NCQA Committee and QIHEC.

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HEDIS® MY2022 Preliminary Results

Quality Assurance Committee Meeting

June 14, 2023

Our Mission

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

Our Vision

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

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Background

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CalOptima Health

Healthcare Effectiveness Data and Information Set (HEDIS)

- HEDIS is a set of standardized measures designed to provide buyers and consumers with reliable comparison of health plan performance
- HEDIS includes near 100 measures across six domains of care and relates to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes
- HEDIS results are audited by National Committee for Quality Assurance (NCQA) certified auditors.
  - All measures passed audit and are reportable for MY2022
- Medical records review was required for 40 measures and sub-measures with 7,044 chart chases.
  - Chart retrieval rate is approximately 99%

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HEDIS and Regulatory Requirements

- Department of Health Care Services (DHCS)
  - Managed Care Accountability Set (MCAS) — select measures must achieve minimum performance level (MPL), which is the national Medicaid 50th percentile
  - Financial sanctions or corrective action plans may be imposed for measures that do not meet the MPL
- NCQA
  - HEDIS measures are used for Health Plan Ratings and Health Plan Accreditation
- Centers for Medicare & Medicaid Services (CMS)
  - HEDIS measures are used in Star Ratings (OneCare)
  - Quality withhold payment (OneCare Connect)

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Medi-Cal MY2022 Results

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Medi-Cal Performance Summary

- MCAS measures with minimum performance level (MPL) requirements achieved the MPL except for two newly selected measures
  - Lead Screening in Children rate 63.02% (MPL 63.99%)
  - Follow-up After ED Visit for Mental Illness (30-day) rate 52.75% (MPL 54.51%)
- Well-Child Visits in the First 30 Months of Life (0-15 months) measure improved and reached MPL
- Health Plan Rating (HPR): projected to maintain 4.0 out of 5.0 rating
  - HEDIS Prevention measures projected to maintain 4.0 rating
  - HEDIS Treatment measures projected to maintain 3.5 rating
  - CAHPS Patient Experience measures projected to reduce from rating 2 to 1.5
  - 5 measures are moved to a higher measure rating and 6 measures moved to a lower measure rating compared to prior year

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Top Opportunities for Improvement: Medi-Cal

- Measures that did not meet the MPL
  - Lead Screening in Children (LSC)
  - Follow-up After ED Visit for Mental Illness (FUM)
- Individual HPR measures that scored below 3.0
  - Appropriate Testing and Care, children with sore throat (CWP rating =1)
  - Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB rating = 2)
  - Follow-up After High-Intensity Care for SUD (FUI rating = 1)
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications (SSD rating = 2)
  - Pharmacotherapy Management of COPD Exacerbations – Corticosteroid (PCE rating = 2)
  - Pharmacotherapy for Opioid Use Disorder (POD rating = 2)

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Medicare MY2022 Results

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Medicare Performance Summary - OneCare

- HEDIS Star Ratings measures
  - Projected to reach 3 and above except one measure, based on available Star Rating cut off value*
    - Plan All-Cause readmissions (PCR)
      - Return in MY2022 weighted 1, increase weight to 3 in MY2023
  - Transitions of Care measure: added 3 sub-measures
  - New Star measure: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
  - The rate of Controlling High Blood Pressure measure (CBP) is lower than last year's rate, and the weight increased from 1 to 3
  - The rate of Eye Exam for Patients With Diabetes (EED) measure is lower than last year's and moved the rating from 5-Star level to 4-Star level

* Star Rating cut-off values are based on 2023 Star Tech Notes updated 1/19/2023

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OneCare HEDIS Star Rating Measures

Star Rating HEDIS Measures	MY2021	MY2022	2023 Star Rating	Estimated 2024 Star Rating*
Breast Cancer Screening	66%	65%	3	3
Controlling High-Blood Pressure	71%	68%	3	3
Colorectal Cancer Screening	62%	64%	3	3
Care for Older Adults - Medication Review	84%	84%	4	4
Care for Older Adults - Pain assessment	84%	85%	3	4
Diabetes Care - Blood Sugar Controlled (A1c>9)	81%	78%	4	4
Diabetes Care - Eye Exam	79%	73%	5	4
Diabetes Care - Medical Attention for Nephropathy	94%	94%	4*	4
Statin Therapy for Patients with Cardiovascular Disease - treatment	85%	82%	4	3
Transitions of Care	MY 2022 includes all 4 sub-measures			TBD
Plan All-Cause readmissions	12%	9%	NA	TBD
Osteoporosis Management in Women Who Had a Fracture	Denominator is too small to report. Should be reported in MY2023 with adding OneCare Connect members			

* Star Rating cut-off values are based on 2023 Star Tech Notes updated 1/19/2023

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Medicare Performance Summary – OneCare Connect

- No Star Rating for OneCare Connect population
  - OneCare Connect members will be combined with OneCare members for next year's HEDIS reporting for Star Ratings measures
  - Overall, HEDIS rates for OneCare Connect members are slightly better than OneCare members in MY2022
- Quality withhold measures for contract year 2022
  - Follow-up After Hospitalization for Mental Illness (30-day) improved and met benchmark
  - Controlling High-Blood Pressure does not meet benchmark
  - Plan All-Cause readmissions does not meet benchmark

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Top Opportunities for Improvement: Medicare

- Star measures with 3-fold weight
  - Controlling Blood Pressure (CBP) – (rate 68% vs 4-Star cutoff 73%)
    - CBP rate was negatively impacted due to lack of BPs found in provider medical records (telehealth visits do not document BP)
    - BP can be submitted through claims by using CPT II code
  - Diabetes Care - Blood Sugar Controlled (rate 78% vs 5-Star cutoff 83%)
    - HbA1c level can be submitted through claims by using CPT II code
- New Star Rating Measures
  - Transitions of Care measures: all less than national 50th percentile benchmarks
    - Notification of Inpatient Admission and Receipt of Discharge Information need be documented in the charts
  - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC): rate less than national 25th percentile benchmark

* Star Rating cut-off values are based on 2023 Star Tech Notes updated 1/19/2023

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Next Steps

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The Future of HEDIS – Digital Measures

- Electronic clinical data systems (ECDS) is a HEDIS reporting standard for health plans collecting and submitting quality measures to encourage health information exchange and use all available clinical data for patient care and quality improvement
- Breast Cancer Screening (BCS) measure will transition to ECDS only reporting for MY2023
- Colorectal Cancer Screening (COL) measure will transition to ECDS only reporting for MY2024 (no medical record review is allowed)
- NCQA Goal: All HEDIS measures digital in 4 years
  - Obtaining proof of service in a paper medical record will no longer be permitted and EMR data exchange becomes critical

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Next Steps

- Present results to Stakeholder Groups
- Calculate HN Quality Rating Scores and P4V payments
- Prioritize and implement strategies on low performing areas
  - Loss of Kaiser is expected to negatively impact future quality scores
  - Expand data sources to identify non-compliant members in near real-time
  - Continue to prepare for digital reporting
  - Start health disparity analysis to further refine focus areas
- NCQA Health Plan Rating announced in September 2023
- Draft 2024 Star Ratings in September 2023

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Board of Directors' Quality Assurance Committee Meeting
June 14, 2023

PACE Member Advisory Committee Update

Committee Overview
The 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.

March 28, 2023: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, COVID updates, and transportation. We continue to have two shifts (am/pm), allowing up to 35 participants per shift totaling 70 per day. We continue to monitor any trends and adjust operations as needed. All participants are assigned to pods, with social distancing in mind, and must wear mask. The clinic and skilled rehabilitation appointments continue to operate as usual. The Director also introduced Dr. Donna Frisch to the group as our new PACE Medical Director. Director shared that the PHE will be ending May 11 and we will resume our services to pre-covid operations (mask will be optional), COVID testing protocols will continue as usual if someone is symptomatic. The transportation manager attended the advisory meeting to allow participants to share concerns, thoughts, or ask questions.

COVID-19 Updates
Jennifer Robinson, Quality Improvement Manager, provided updates related to COVID-19 numbers and status. Jennifer reported case numbers and hospitalizations significantly going down. At the center we have seen a decrease in positive cases as well. We continue to require masking at the center with KN95 for everyone's safety. PACE is continuing our vaccination efforts and providing education to participants. Jennifer reminded the group that we are still offering the bivalent booster. Currently, 65% of our participants are up to date on their COVID vaccines.

PMAC Member Forum

- Participants mentioned that transportation has been slightly better and spoke about certain drivers. The secure transportation manager mentioned making staffing changes and will continue to assess our needs.
- Participants shared comments that were placed in the suggestion box and areas that they would like the team to assess. These areas include:
  - Assessing if sports should be a daily topic or not.
  - How to incorporate different activities.

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CalOptima Health Board of Directors'
Quality Assurance Committee Meeting
June 14, 2023

Quality Improvement Health Equity Committee First Quarter 2023 Report

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Summary

- Quality Improvement Health Equity Committee (QIHEC) met on January 17, 2023; February 14, 2023; and March 14, 2023
- The following departments and subcommittees reported to QIHEC in Quarter 1 (Q1):
  - Behavioral Health Integration (BHI) Department
  - Case Management Department
  - Communications Department
  - Credentialing and Peer Review Committee (CPRC)
  - Grievance & Appeals Resolution Services Committee (GARS)
  - Medical Management Department
  - Member Experience Committee (MEMX)
  - Population Health Management Department
  - Program Development Department
  - Quality Improvement (QI) Department
  - Utilization Management Committee (UMC)
    - Benefits Management Subcommittee (BMSC)
    - Pharmacy & Therapy (P&T)
  - Utilization Management (UM) Department
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
- Approved the following:
  - QIC Meeting Minutes 12.13.22
  - QIC Meeting Minutes 01.17.23
  - QIC Meeting Minutes 02.14.23
  - 2022 Quality Improvement Program Evaluation
  - 2023 QI Program with Workplan
  - Quality Improvement Policies GG.1618: Request for Medical Records
  - Policy GG.1110: Primary Care Physician Definition, Role, and Responsibilities
  - External_AMR Board Certified Reviewers_2023
  - External_MRIoA Board Certified Reviewers_02.27.2023

    - Internal CalOptima Health Board Certified Reviewers_2023
- Accepted and filed minutes and QI Work Plan from the following committees and subcommittees:
    - 2022 QI Work Plan Q4
    - 2023 Quality Improvement (QI) Work Plan Q1
    - GARS Meeting Minutes 11.16.22 Q3_Final
    - Member Experience Agenda and Minutes 12.08.22
    - Member Experience Agenda and Minutes_ 10.12.22 Approved
    - UMC Meeting Minutes_11_17_2022
    - WCM CAC Meeting Minutes_08_16_2022
    - External_AMR Board Certified Reviewers_2023
    - External_MRIoA Board Cerfitied Reviewers_02.27.2023
    - Internal_CalOptima Health Board Certified Reviewers_2023

QIC Quarter 1 2023 Highlights

QI Program Element	Key Activity
Program Oversight	• Annual Conflict of Interest and Confidentiality Forms were collected. • 2022 QI Evaluation and the 2023 QI Program and Workplan were presented and approved.
QI Program Resources	Added new medical director and staff that joined the QIHEC Committee in Q1 2023: • Michael Weiss, DO Vice President of Population Health at CHOC Health Alliance • Said Elshihabi, MD, CalOptima Health Medical Director for Spine • Linda Lee, CalOptima Health Executive Director of Quality
QIHEC Subcommittees	WCM CAC Committee chair, Dr. Thanh-Tam Nguyen, provided an update on their August 16, 2022, and November 16, 2022 meetings along with a copy of their detailed meeting minutes. • Shared tribute on passing of Committee member John Cleary MD. • Marsha Choo, Quality Improvement Director provided a follow-up on Whole Child Model Network Adequacy. In December, two health networks were identified as noncompliant and are now reported as compliant. • DHCS Integrated California Children's Services & Whole Child Model Dashboard measures showed that CalOptima Health's rates for WCM measures were comparable to other health plans in California. • WCM Member Inquiries, Grievances and Appeals Resolution, BH, and CalAIM provided updates.

QI Program Element	Key Activity
	• California Department of Health Care Services Notice updates were shared. • The Committee requested agenda topic around CCS members' age out process.

QIHEC Subcommittees	Marsha Choo, Director of Quality Improvement, provided an update on Member Experience Committee (MemX).
	• MemX met October 12, 2022, and December 08, 2022
	• 2022 Behavioral Health Member Experience Report
	  o The survey focuses on Mental Health (MH) Services (medication and therapy services) and Applied Behavior Analysis (ABA) Services did not meet the 85% satisfaction goal. MH areas did not meet the goal and 'As a Result of Treatment' metric was not met for MH and ABA.
	• 2022 Provider Satisfaction Survey
	  o 69% of providers are satisfied with CalOptima Health
	  o Provider Relations is working with other departments on efforts to address areas of dissatisfaction.
	• One Care/One Care Connect Consumer Assessment of Healthcare Providers and Systems survey (CAHPS) Scores and CY2023 Stars CAHPS Measures
	  o OneCare's CAHPS performance dropped significantly in each category, resulting in a Part C rating of 2.5.
	  o Opportunities for improvement in the areas of customer service and access and availability of care.
	  o Approval by committee to discontinue Plan-Do-Study-Act (PDSA), but issue corrective action plans to Health Networks (HN) below a 2.5 for HN Quality Rating for Member Experience
	  o Issue a Request For Proposal with a CAHPS improvement vendor to improve CalOptima CAHPS scores
	• Network Adequacy Workgroup updates
	  o Annual Network Certification (ANC) submitted to California Department of Health Care Services (DHCS) according to All Plan Letter 23-001.
	  o Q3 2022 Network Adequacy Plan and HN. CalOptima Health met network adequacy standards at the plan level for all lines of business with exception for OneCare Time/Distance: Speech Therapy. Performance for HN has not changed from the previous quarter and is the same for Q4 2022.
	• Timely Access PDSAs

QI Program Element	Key Activity
	○ 36 Timely Access PDSAs were issued to 12 Health Networks in January 2022 based on 2022 survey data. Submissions were received from all HNs. All PDSAs were approved and closed. • 2021-2022 Timely Access Survey to monitor telephone and appointment wait times for all lines of business was fielded between Sept 2021 – July 2022. ○ Appointment Wait Time and Administrative Measures improved from last year and most of the Provider/Appointment types did not meet the 80% Minimum Performance Level. ○ CalOptima staff to work with Provider Relations and send provider non-compliance letters and issue an escalation letter and Corrective Action Plan to HNs not meeting 80% minimum performance compliance rate for appointment and telephone wait time standards.
QIHEC Subcommittees	Kelly Giardina Executive Director of Clinical Operations presented the UMC's Q4 report. • CalOptima Health's direct networks saw a downward trend between Q1 2022 to Q3 2022 for one day stays. • All three quarters of 2022 showed Sepsis as the top diagnosis for inpatient, one day stays. • All cause readmissions had a slight increase from Q1 2022 to Q2 2022 by 0.003% and a 14% decrease from Q1 2022 to Q3 2022 for all cause readmits within 30 days for CalOptima Health's direct networks. • Interventions to address utilization trends and operational efficiencies ○ Clinical: Emergency Department (ED) Pilot at high volume facility for one day stays, inpatient rounds with high volume facilities, complex discharge team, and real-time peer to peer ○ Strategic: On-going monitoring of daily inventory and improve TAT, focus on ED readmissions/LOS, and minimizing institutional length of stay ○ Process Improvement: staff education/training/IRR, monitoring of staff productivity, and staff coaching with clinical trainer
Performance Measure Goals	Linda Lee, Executive Director of Quality presented methodology for Medi-Cal and Medicare 2023 Performance Measure Goals. • Methodology for Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS measures was adopted. • Short term goal is to increase current performance to the next percentile and/or Star rating. • Long term goal is to achieve top quality rating with goals set at the 90th national percentile of National Committee for Quality Assurance (NCQA) or Medicare 5-Star

QI Program Element	Key Activity
	• The CAHPs measures are quadruple weighted for stars and have a large impact on the patient experience measures. • In the 2023 draft rule for Medicare, they are proposing dropping the CAHPS, weighting back down to 1.5 starting with 2026 Star ratings. CalOptima staff is submitting comments to Centers for Medicare & Medicaid Services (CMS) through ACAP and is in support of that modification
Quality Compliance Concerns	CalOptima staff identified and reported that a letter issue occurred on 12/15/2022 and was reported as critical issue to Guiding Care Team. • There were intermittent issues affecting UM, CM, PHM and BHI departments where users were unable to use the module to create letters and caused delays, however only three of 31,122 were found noncompliant and were corrected in a late entry. • CalOptima Health's continuity plan was in place to produce letters and attach to clinical platform to ensure universe and regulatory reporting are not impacted by the workaround. • Permanent Fix was patched 3/15/23 with no further incidents.
Monitoring Quality Metrics	• Tyronda Moses, Director of Grievance and Appeals provided an update on Q4 Grievance and Appeals. Grievances increased 51.8% from the previous quarter. Issues contributing to the higher rate and trends were identified and remediation plans were implemented. • Appeals for all Lines of Business show no trends or areas of concerns.
Strategic Initiatives	Annapryssma Safari, Manager of Population Health Management, presented changes to the Initial Health Appointment (IHA) through the Population Health Management strategies. • Members must be seen by a provider for an IHA within 120 of enrollment. • Staying Healthy Assessment- The SHA has been discontinued. • Goal to reach at least 50% completion rate overall. • Notification, education, and training is going to Members and Providers
Strategic Initiatives	California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) • Offered for populations of focus • Members participating in WPC and/or HHP were automatically transitioned into ECM • EMC and Community Supports rolled out January 2022 to initial eligibility populations, then in January 2023 to adults eligible for Long-

QI Program Element	Key Activity
	Term Care and residents in adult nursing facilities, and in July 2023 children will be added. • Rental supports are being considered as an additional community support
Strategic Initiatives	CalAIM Homeless Health Initiatives (HHI): Homeless Response Team (HRT) • Homelessness Response Team – continued virtual office hours and provided some in-person outreach. This team will be transitioning to CalAIM to provide more targeted outreach to contracted housing services providers. • Clinical Field Teams on average received about one call per day and provided support when needed. Homeless Clinic Access Program (HCAP) also continued providing services at local shelters. Both programs ceased in December 2022. However, HCAP will be re-launched this summer after enhancing the program with lessons learned. • Street Medicine services will launch in April 2023 with the selected provider. • Street Medicine services and Homeless Clinical Access Program was set to discontinue but staff are taking lessons learned to relaunch with a restructure for services in Long-Term Care. • The Housing and Homeless Incentive Program (HHIP) - Board committed $40M to launch efforts and created a Notice of Funding Opportunity to distribute those funds. Two payments have been received, $4.1M in return for local homelessness plan and $8.34 for investment plan. These funds will be distributed in the coming months following said investment plan. Goal will be to show continued progress on DHCS metrics to enable and draw future dollars. Areas are dedicated to increase the connection that organizations can make to permanent support housing or permanent support of housing. Recipients are mostly community-based organizations looking for capacity to support and create a plan. Future investments would be continuum supports to provide supportive services and maintain caseloads.
Strategic Initiatives	Megan Dankmyer provided an update on the 2024 Model of Care for OneCare and was approved by QIHEC. • CMS approved the 2024 Model of Care through 12/31/26. • The Dual-Eligible Special Needs Plan (D-SNP) Model of Care has a new Face-to-face encounter requirement for either in-person or through a visual, real-time, interactive telehealth encounter. • California specific requirements were added into the Model of Care based on the ‘D-SNP Policy Guide: Contract Year 2024’ requirements.

QI Program Element	Key Activity
Strategic Initiatives	Janis Rizzuto presented an update on Redetermination Efforts of Medi-Cal benefits that began in April of 2023. • Information series were conducted around outreach efforts. • CalOptima Health staff are educating Members on the renewal process. • Collaborating with CalFresh

Quality Improvement Projects	BH Quality Improvement Projects provided by Diane Ramos, Manager, Behavioral Health Integration
	• Student Behavioral Health Incentive Program (SBHIP)
	  o Focused on partnerships within the counties, the school districts, managed care plans and the county behavioral health to provide mental health services on the school campus or near school campus.
	  o All 29 Orange County school districts are participating in SBHIP
	• Behavioral Health Integration Incentive Program (BHIIP) was completed in December 2022. Quarter 4 milestones were due and reported in March along with the 2022 Annual Report to DHCS.
	• Applied Behavior Analysis (ABA) Pay for Value (P4V) was completed in December 2022.
	• Follow-Up After Hospitalization for Mental Illness (FUH)
	  o Had a decrease in admits but an increase in readmits. Patients were not completing follow-up visits. BH attempted to help by outreaching members for appointments but was unsuccessful due to the inability to reach members.
	• Follow-up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication (ADD) rates.
	  o Continue to perform well and staff continues to outreach to members.
	• Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) is making progress.
	  o Staff continue with outreach to providers and continue to monitor for barriers.
	• Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)
	  o Barriers were found in obtaining the ED records as remediation, staff is training to access ED real time data.

Quality Improvement Projects	• Performance Improvement Projects (PIPs) – Medi-Cal - Improving Breast Cancer Screening (BCS) Rates for Korean and Chinese CalOptima Medi-Cal Members ages 50-74 (March 2020-December 2022).

QI Program Element	Key Activity
	○ The intervention was for CalOptima Health to partner with provider offices and mobile mammography vendor for a mobile mammography community event to eligible CalOptima Health Community Network members. ○ Four mobile community events were completed in 2022 and a total of 119 mammograms were performed, of those 93 were CalOptima Health Community Network members. ○ Looking to expanding the project by working with radiology centers at FQHC. • Performance Improvement Projects (PIPs) – Medi-Cal - Improving Well-Care Visits for Children in their First 30 Months of Life (W30) (June 2021-December 2022) ○ The goal was to increase the percentage of well-care visits among Medi-Cal members turning 15 months old to 44.96% by December 2022 Remeasurement. • COVID Quality Improvement Project (QIPs) – Medi-Cal - Women's Health – Cervical Cancer Screening (CCS) (September 2021- September 2022) ○ CalOptima Health in collaboration with the contracted Health Network (HN) identified provider offices that have a high volume of CalOptima Health Medi-Cal members for CCS and are performing low for the measure. A provider office staff incentive was provided if a predetermined goal was accomplished at the end of each intervention cycle. Three HN provider offices completed all 3 cycles of the intervention with a combined CCS denominator of 4,128 members with target outreach list of 1,833 members. The final combined CCS rate was 61.92% (2556/4128). • COVID Quality Improvement Project (QIPs) – Medi-Cal - Child and Adolescent Health – Childhood Immunization Status (October 2021-September 2022) ○ The goal was to increase the immunization rates of Medi-Cal members turning 2 years of age who are due for vaccinations. ○ Next steps were to add each date of Service and vaccination compliance for each vaccine type for CIS-10 to the gap report for visibility for providers, identify members at time of birth, and start outreaching sooner. • COVID Quality Improvement Project (QIPs) – Medi-Cal - Behavioral Health - Diabetes Screening for People with Schizophrenia or Bipolar

QI Program Element	Key Activity
	Disorder Who are Using Antipsychotic Medications (October 2021-December 2021). o Intervention was to conduct outreach to top 50 prescribing providers with the highest volume of members (totaling 1,234) in need of screening in 2021. o 188 of the 1,234 members (15%) received a screening which was low but MY2021 goal was met. 71% to 75% increase noted in year-to-date rates. o Final report was submitted to DHCS April 2022. • Chronic Care Improvement Projects (CCIPs) – Medicare and Medi-Cal (NCQA) - Emerging Risk A1C 8.0%-9.0% (January 2020 to December 2022) o CalOptima Health's Health Coaches conducted telephonic outreach to Emerging Risk members to help them identify solutions to manage their A1c levels below 8.0%. These are eligible members with diabetes who had an A1c test result below 8.0% previously but tested between 8.0% and 9.0% in their most recent A1c test. In Q4 2022, 230 members were successfully contacted. • Quality Improvement Projects (QIPs) – Medicare and Medi-Cal (NCQA) - Statin Use for Diabetics Adherence Improvement (January 2020 to December 2022) o Intervention was quarterly member mailing campaigns to reduce cardiovascular risk among CalOptima members diagnosed with diabetes. Mailings were sent to 3,407 members (all LOBs); and the rate of non-compliant members decreased meeting the improvement goal. • Plan, Do, Study, Act (PDSA) - Well-Child Visits in the First 30 months (W30-2+) (November 2022-December 2023) o Cycle 1 Intervention: Telephonic call campaign 2/1 - 2/17 to members 12-30 months old who identify as Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, or Asian Indian.
Quality Improvement Projects	Diabetes Care Program (Pilot) • Due to CalOptima Health changes this was paused and reassessed to clarify the Members' needs. • Staff decided on a Target population (N = 20*) starting with CalOptima Health Community Network Adult Latino members with poorly

QI Program Element	Key Activity
	controlled diabetes (A1c ≥ 8% (baseline)) with the goal to lower A1c to < 8% to reduce complications • After 12 months will reevaluate for expansion
Plan Performance Monitoring and Evaluation (PPME)/Quality Improvement Program Effectiveness (QIPE)	• All lines of business are in compliance with outreach requirements for the Health Risk Assessment. HRA completion is below established benchmarks. • Oversight of Model of Care - Each HRA was reviewed and sent to health networks for care plan development. MOC tracking file was undergoing additional revision and goal. • OneCare Connect sunsetted on 12/31/2022 and members transitioned to OneCare. • Case Management monitoring and reporting for QIHEC and QI workplan will pivot to mirror regulatory expectations for 2.1 HRA collection within 90 days of eligibility and 3.2 ICP completion within 90 days of eligibility.

Credentialing	• The volume of credentialing applications continued to increase for both practitioners and organizational providers.
	• There was one disciplinary action taken against a provider in 2022.
	• Sanction activity in 2022
	  ○ CMS Preclusion List (4)
	  ○ DHCS Restricted Provider List (9)
	  ○ Office of Inspector General (OIG) (0)
	  ○ System for Award Management (SAM) (0)
	  ○ Medi-Cal Suspended and Ineligible (S&I) (0)

Facility Site Review (FSR)/ Medical Records Review (MRR)	• FSR's have remained relatively the same from 2022 to 2021. • MRR increased in issued CAPS due to the change in DHCS requirements. The provider's office staff were having trouble meeting the new requirements. Provider trainings on the new tools and requirements were offered to provider offices and staff provided individual office assistance when needed. • FSR/MRR audit backlog remained low because during the Public Health Emergency (PHE), CalOptima Health staff continued to perform audits despite some limited provider office hours and/or staff availability.
Physical Accessibility Review Survey (PARS)	• The total number of PARS surveys increased in 2022 due to the end of PHE. • The percentage of PARS with Basic access in 2022 was 40%, in 2021 was 25%.
Potential Quality Issues	Two separate Fair Hearings occurred in 2022 and the CPRC upheld the recommendation of the Fair Hearing Committee. One physician was

QI Program Element	Key Activity
	recredentialed and the other was not. An 805 report was made to the Medical Board of California against the provider who was not recredentialed. Newly opened PQI cases have increased dramatically in the last two years. The percentage of cases that were identified as Quality of Care increased to 23% in 2022, as compared to 12% in 2021 and 8% in 2022. Those with Quality-of-Care issues were predominantly for medical care with most being related to mismanaged care and treatment delay, inappropriate treatment or complications. The reason for the increase may be related to improved identification by the medical directors.
Incident Reports on Nursing Facilities (NF) and Community-Based Adult Services (CBAS) Centers.	Falls and Non-Critical incidents for CBAS increased in 2022 and were largely due to positive COVID-19 results. There were no Critical Incidents reported by Nursing Facilities in 2022. There were 35 CBAS audits performed in 2022 and no CAPs were issued. There were 27 Nursing Facility audits performed in 2022 and no CAPs were issued, and 3 unannounced site visits were performed.
Provider Preventable Conditions	In 2022 there was 1 Provider Preventable Condition (PPC) identified for foreign object retained following surgery.
Board Certified Specialist List	List of board-certified consultants used to assist in making medical necessity determinations for medical necessity determinations was reviewed and accepted.
QIHEC Action Items:	• Requested a report on Liver disease diagnosis report with age category data (<21-year-old). In February staff reported that non-alcoholic fatty liver disease represents the most common cause of liver disease among pediatric members. Strategies for prevention are by member support through Health & Nutrition education for children with high BMI and their families. Item was closed 2/14/23. • Requested a systematic approach to address the challenges of gathering data at first 6 months of age. In May, Dr. Sinha presented an update with challenges and root cause analysis. Promotion of early Medi-Cal enrollment for newborns will lead to improved access for well-care visits and improve data capture for newborns. Item was closed on 5/9/23. • UMC was asked to include each HN and CCN aggregate in their next report and WCM CAC was asked to present CalOptima Health's Age out process at their next report, due in June. Item remains open until 6/13/23.

Attachments

Approved at QIHEC throughout Q1 2023: 2023 QI Workplan – First Quarter

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Program Oversight	2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2023	Marsha Choo	Laura Guest	Approved: QIC 2/14/2023, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	Laura Guest	Approved: QIC 2/15/2022, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2023 Utilization Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Teresa Smith	Approved: UMC Committee via eVote on 4/7/2023, QIC 4/11/2023		
Program Oversight	2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Teresa Smith	Approved: UMC Committee via eVote on 4/7/2023, QIC 4/11/2023		
Program Oversight	Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	Barbara Kidder	Updated and drafted a PHM strategy to meet NCQA requirements and currently in the process of revising and updating to meet DHCS contractual requirements. The goal is to have a single document that aligns with all regulatory requirements, NCQA accreditation and strategic priorities for the organization.	PHM Strategy will be presented to QIHEC in Q2 for feedback and continue to be refined with CalOptima Health leadership to include a comprehensive scope of services and strategies. PHM Strategy will be due to DHCS in October 2023.	
Program Oversight	CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	Danielle Cameron	1. The ECM Academy launched in January 2023 with 20 community health centers and community-based organizations participating. They received incentive funding to support building internal capacity for this service and will receive training through June 2023. They are anticipated to be contracted and launch services in July 2023. 2. CalAIM Team brought on 19 new providers in Q1 of 2023 and expanded the contracts of 8 current providers to expand their offering of additional services. 3. As of 3/31/2023, a total of 12,491 members had authorization for CalAIM benefits. In reviewing claims for services, 620 were receiving ECM only, 6,208 were receiving community supports, and 1,063 were receiving both ECM and community supports. 4. The CalAIM team is finalizing the community supports policy guidelines that includes requirements for documentation and quality metrics. Once this policy guide is complete, training will be conducted with providers and will be integrated into an overal quality monitoring program. 5. Healthcare in Action was fully credentialied and contracted in Q1. Services began on 4/3/2023. 6. CalOptima Health staff have executed grant agreements and award payments to selected grant recipients for each of the following funding areas, as a result of the notice of funding opportunity as follows: a. Infrastructure Projects that will increase housing navigation and organizational capacity to connect individuals to permanent supportive housing: Total of payments recommended for award: $5,832,314. b. Capital Projects to increase the current affordable and permanent housing pool: Total of payments recommended for award: $21,000,000. c. Equity Grants for Programs Serving Underrepresented Populations of people experiencing homelessness: Total of payments recommended for award: $3,021,311. 7. Planning is still under way for the HCAP 2.0 program. Focus groups are being conducted with previous providers of the HCAP program to help inform the evolution of the service.	All programs will continue to be stewarded forward.	
Program Oversight	Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy project	1) 4Q 2022 2) 4Q 2022 3) 3Q 2022	Katie Balderas	Barbara Kidder	1. The Annual Wellness Visit incentive for Medi-Cal members added a requirement for providers to conduct an Health Related Social Needs Assessment 2. Worked with EPMO to draft a SOW for a close-loop referral tool. Vendor Management provided budgetay estimates from two potential vendors (FindHelp and WellSky) 3. Launched the Health Literacy for Equity (HL4E) program in collaboration with the Orange County Health Care Agency, Social Services Agency, St. Jude and he Institute for Healthcare Advancement.The goal of the program is to partner with other systems in Orange County to increase organizational health literacy through a variety of activities including leadership commitment, training courses and improvement projects.	Data evaluation of Annuall Wellness visits inentives to evaluate HRSN reporting The Close loop referral tool changed priority status since DHCS changed the timeline/requirement for the close loop referral HL4E - training, certification, organizational assessment will continue trhough April 2024.	
Program Oversight	**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews);Quality of Care cases leveled by committee.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Laura Guest	Marsha Choo	I. FSR/PARS/NF/CBAS: A. FSR: Initals=8; Periodic=40; CE CAPs=39; FSR CAPs=39. Initial MRR=11, Periodic MRRs=53; MRR CAPs=42; Failed FSRs=3; Failed MRRs=3. B. PARS: PARS=133; Basic=60(45%); Limited=73 C. CBAS: No Critical Incidents reported, Non-critical declined; Fall similar to previous quarters; COVID dropped to nearly 0. Audit=13; CAPs=4; Unannouced Visits=0. D. NF: No Critical Incidents were reported in Q1. Audit=3; CAPs=0; Unannounced Visits=0. II. Credentialing: CCN initial credentialing=26, recredentials=29, BH initial credentialing=10, BH Recredentialing=13 III. PQIs There were 158 cases closed in Q1. There were 16 PQI cases presented to CPRC. Medical Care: Mismanaged Care was the greatest category/subcategory of PQIs. The number of QOC Grievances reviewed were 502, declined grievances were 91. Created report to monitor TAT of Declined Grievance PQIs with goal of MD review in 30 days and TAT of PQIs with a goal of MD review in 90 days. Requested additional staffing to accommodate additional workload.	I. FSR/PARS/NF/CBAS A. FSR: Continue to audit. B. PARS: Continue to audit C. CBAS:Continue to audit and remind centers to report critical incidents. D. NF: Re-evaluate current processes. One LVN retired, so will recruit for this position. II. Credentialing A. Continue to perform credentialing and recredentialing if CCN and BH providers. B. Review and provide feedback to the delegated CCN provider groups regarding the monthly credentialing universes they submit. III. PQI 1. Review QOC grievances, Declined grievances and PQIs. Due to backlog of PQIs, hire temp to assist with medical record requests. Meet with Quality Medical Director to evaluate method for QOS cases that don't involve a PQI.	
Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Tyronda Moses	Heather Sedillo	GARS Committee (held on 2/6/2023) was presented Q4 2022 data and reviewed the overall CY 2022 trends and remediation steps. The highest trending complaint reason remains the quality of service performed by our NMT servicer. However, the complaints remain under 1% of the total rides (they are meeting the service levels in the contract). There are additional collaboration steps that are being considered. GARS will continue to monitor and assess for remediation/reommendations for improved performance. Announced also during Committee were regulatory changes impacting DHCS reporting for Q4 and CMS/DHCS OneCare AIP impacts to appeals timeframes and grievance processing. Meeting minutes have been submitted	GARS continues bi-weekly communication with our NMT service provider for any actionable process improvements. next GARS Committee is scheduled for Q1 2023 review on May 8	

2023 QI Work Plan 1Q

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Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Marsha Choo	Karen Jenkins	In Q1, MemX Committee has reviewed/discussed the following: **3/16/2023**: •Charter Review •Member Experience Workplan •OC Customer Service Member Outreach Campaign •Customer Service Interpreter Service •GARS Update •Network Adequacy Workgroup Update •Timely Access Workgroup Update & Discussion •CAHPS •Veyo Tranportation	In Q2 MEMX Committee has two meetings scheduled, April 12 and May 17.	
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	Stacie Oakley	Teresa Smith	UMC met 2/23/23 and is on track to meet quarterly. Meeting minutes are available for review. Committee did the annual review of criteria used clinical decision making and Hireachy of Clinical Decision making. Reviewed and approved IRR reports. 2022 Utilization Metrics: 4th Quarter, Pharmacy, BH and LTSS update.	UMC scheduled 5/25/23	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: February 21, 2023 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (~~4/11~~ 6/13QIC) 2Q23 update (~~7/11~~ 6/13 QIC) 3Q23 update (~~10/10~~ 9/12 QIC) 4Q23 update (~~Jan 2024~~ 12/12 QIC)	T.T. Nguyen, MD	Gloria Garcia	WCM CAC met 2/21/23 - See meeting minutes for details. A copy of those meeting minutes will be presented along with the WCM CAC report at the June 13, 2023 QIHEC.	Q2 meeting is scheduled for May 16, 2023. Continue with tranistion workgroup and follow up with HN relation to increase the number of contracted CCS paneled providers.	
Program Oversight	Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital		The Pay for Value (P4V) team generates a Prospective Rate (PR) report each month for all participating health networks and CalOptima Health to allow health networks their progress on clinical HEDIS measures in the P4V program. Performance on each measure is compared to the overall CalOptima Health performance, as well as to the National Medicaid HEDIS benchmarks established by NCQA.	The overall health network quality rating (HNQR) is the weighted average of the network's HEDIS and CAHPS measure ratings, as well as accreditation bonus points and is calculated on a scale of 0-5 (5 being the highest). The final HNQR is usually complete after the final HEDIS and CAHPS results are available in the fourth quarter of the following year.	
Program Oversight	Improvement Projects OneCare CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	end of 2Q2023	Helen Syn	Melissa Morales	Baseline Data: **PR Report February 2023** **HbA1C <8 Total (HBD):** MC: Num 4,801/ Den 43,251 = 11.10% OC: Num 528/ Den 3,707 = 14.24% **HbA1c>9 Total (Poor Control) (HBD):** MC: Num 37,427/ Den 43,251 = 86.53% OC: Num 3,088/ Den 3,707 = 83.30% **Eye Exam for Patients with Diabetes (EED):** MC: Num 9,967/ Den 43,251 = 23.04% OC: Num 1,140/ Den 3,707 = 30.75% **Kidney Health Evaluation for Patients with Diabetes (KED):** MC: Num 3,961/ Den 43,707 = 9.06% OC: Num 473/ Den 4,586 = 10.31% **Statin Use in Persons with Diabetes (SUPD) OC only:** Pending data 1) Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 2) SPD Statin mailers (bi annual): MC Total sent: 6,606 members, OC Total sent: 651 members. 3) Text Message Campaign A1C and Diabetes Eye Exam: Pending 4) IVR Campaign A1C and Diabetes Eye Exam: slated for Q3 2023/Q4 2023 5) Live Call Outreach: Pending 6) VSP Eye Exam Reminder Letters: MC Total sent in Q1 2023: 1,276, OC Total sent in Q1 2023: 533 7) Member Incentive: MC A1C Test: 19 approved, 2 denials, MC Eye Exam: 38 approved, 4 denials OC none, slated for distribution mid/late May 2023.	1) Track submitted diabetes member incentive forms 2) Continue Statin Mailer in Q3 2023 3) Obtain results from text message campaign 4) Obtain results from IVR campaign 5) Obtain results from Live Call Outreach campaign 6) Obtain results from VSP Eye Exam Reminder Letters	
Program Oversight	Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	Michelle Nobe	1) Clinical PIP - focuses on DHCS' statewide goals is to reduce the disparity among the Black/African American population for the Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure. Assigned 3/15/23: 2023–26 W30–6 Clinical PIP Topic Data Form.	1) Identify CalOptima Health's Black/African American W30-6+ population to complete the 2023–26 W30–6 Clinical PIP Topic Data Form. Submission due 4/11/23. 2) While the PIP deliverable will focus on the specific Black/African American sub-population, for purposes of a more thorough health equity assessment, the improvement project will include a broader health plan level project.	

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Program Oversight	Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Jeni Diaz	FUM/FUA update provided under Quality of Clinical Care Behavioral Health section below.	FUM/FUA next steps provided under Quality of Clinical Care Behavioral Health section below.	
Program Oversight	Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang		There is no update for Q1. No results until July		
Program Oversight	OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 1Q2023 3. 3Q2023	Linda Lee	Sandeep Mital	Preliminary prospective rates published for OneCare Star and Pay4Value measures. Rates will be tracked monthly throughout year.	1) Stars/CAHPS work groups underway- five work groups (provider, medical management, pharmacy, customer service, and member material development) began on 4/14/2023. Work groups will meet weekly and report bimonthly to Steering Committee. 2) Stars dashboard- plan and Health Network level published beginning 4/7/2023. Dashboard updated and published monthly going forward. 3) OC Pay4Value program underway. Pay4Value score card updated and published monthly beginning 4/7/2023.	
Program Oversight	PPME/QIPE: HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.	1Q23 (5/9 QIC) 2Q23 (8/8 QIC) 3Q23 (11/14 QIC) 4Q23 (February 2024 QIC)	S. Hickman/D. Hood/M. Dankmyer/H. Kim		Regulatory reporting is currently in development and scheduled to be completed by end of April 2023. Communication with Networks has been initiated during Q1 to support tracking and completion to meet ICP benchmarks.	1)Finalize regulatory reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Continue and enhance communication with Networks for tracking outreach and completion to meet benchmarks.	
Program Oversight	NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	Marsha Choo	1)Continued to work with Business owners on the collection of Year one reports. Dashboard with status update will be presented at the April 10 NCQA Committee. Performed mock audits on CCM File review with Health Networks and CalOptima Health Staff. Will be closing Year one document required by end of 2Q2023. Will be performing UM Denial, Appeal, CR mock audits with Health Networks and CalOptima Health Staff. 2) Working with NCQA Consultant on Health Equity Timeline and performing GAP Analysis and next steps.	Upcoming File Review Mock Sessions w/Consultants Credentialing w/Sub-delegates (4/26/2023) Credentialing w/Health Networks (5/3/2023) Credentialing CCN (5/4/2023) UM Medical Denials w/Health Networks (5/8/2023) UM Medical Denials CCN (5/10/2023) Appeals CCN (5/11/2023)	
Program Oversight	Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quaterly reporting to DHCS	1) 4Q2023 2) 4Q2023	Diane Ramos/ Natalie Zavala	Sherie Hopson	1) Completed DHCS follow-up requests for Milestone 1 - Needs Assessment and 4 Targeted Intervention Project Plans 2) Received DHCS approval for funding for Milestone 1 on 3/8/23 3) SBHIP MOU review with Contracting 1/12 4) OCHCA and BHI work session 2/6 5) Executive Director/Manager attended the OCDE Mental Health Workshop meetings - 1/20, 2/10, and 3/3 6) 3/8 Meeting with OCDE purpose was to share with the group the current status of the program, and upcoming deliverables and expectations 7) Initial discussions with potential telehealth vendor, OCDE, and OCHCA regarding their services to support the LEA BH needs - 3/8, 3/27	1) Begin SBHIP MOU development 2) Collect data for upcoming bi-quarterly report due to DHCS end of 2nd quarter 3) Executive Director / Manager continue to attend OCDE Mental Health Workshop meetings 4) COBAR - prepare for May BOD to approve SBHIP funding strategy/plan	
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	Melissa Morales	1) 2023 Member Health Rewards processed as of 3/31/23: CCS: Processed 74 approved 72 for MC BCS: Procesed 102 approved 84 for MC Processed 0 for OC COL: Processed 0 for OC 2) Member, Community and Provider Engagement IVR: CCS Texting: CCS Social Media (Passive): CCS completed January; COL completed March Social Media (Paid): CCS, COL Digital Ad: CCS, COL Print Ad: COL Radio: CCS PBS: BCS, CCS Community Connections: CCS completed January Provider Press: Screening Recommendations. Provider Updates: CCS, COL 3) 2023 February Prospective Rates (PR): Cervical Cancer Screening MC: 42.63% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Goal is set to the 75th Percentile. Breast Cancer Screening MC: 42.21% Measure is performing lower than same time last year and below the 50th percentile (MPL).Goal is set to the 90th Percentile. OC: 48.60% Measure is performaing lower than same time last year. Currently at 2 Star of 43% Goal is set to 4 Star of 70% Colorectal Cancer Screening OC: 47.05% Measure is performing higher than same time last year for OC. Currently at 2 Star of 43% Goal is set to 4 Star of 71%.	1) Continue to track BCS, CCS and COL member health reward. 2) Member, Community and Provider Engagement Mailing: CCS Mailing Schedule April. COL Mailing Schedule May BCS Mailing Schedule June IVR: COL scheduled May BCS Scheduled June Texting: BCS Schedule April Social Media (Passive): Women's Social Media (Paid): COL Digital Ad: COL Member Newsletter: MC Spring 2023 (drop 5/5); BCS COL OC Fall 2023; CCS, BCS, COL MC Fall 2023 Community Connections: CCS, BCS, COL scheduled April for National Cancer Awareness Provider Press: Cancer Screening for July Provider Updates: CCS, BCS, COL (April general cancer screening month)	

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Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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 Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	Barbara Kidder	1) Worked with the Coalition of Orange County to assess capacity of Community Helath Centers to screen for breast, colorectal, cervical and lung cancer - 7 FQHCs reported having on-site equiptment to screen for breast cancer. 3) Developed a mammograp screening pilot for CCN members in partnership with City of Hope. Pilot exprected to launch early May 2023.	Launch mammogram pilot. Explote other efforts such as cancer screening access points with FQHCs that have on-site equiptment and setting up a mobile mammography pilot. Develop cancer screening campaign and landing page in the CalOptima Health Website	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (18 and over).	1) Communication Strategy of COVID vaccination incentive program through June 30, 2023 end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	Linette Lorenzo	1. Targeted Ad Campaign in Q1 for encouraging starting COVID-19 Vaccinations by June 30, 2023 to qualify for a health reward 2. Social Media Outreach about the new program guidelines (i.e. Facebook, Instagram) 3. Internal communication to member-facing staff of program end date via internal FAQ 4. Updated COVID-19 Vaccine Incentive Program (VIP) website to reflect new guidelines 5. Worked with internal stakeholders to update the system flow and logic for faster delivery of outstanding gift cards to members 6. Reached 70.65% vaccination rate for CalOptima members (18 and older).	Texting campaign to address new eligibility guidelines. COVID-19 VIP processing continues as we begin planning for the official end date of the program.	
Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through mutiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	Valerie Venegas	PR HEDIS Rates Q1 (February): Initiation Phase- 40.11%, Continuation and Maintenance Phase- 51.15% 1) Continued member outreach for members that filled initial ADHD Rx 2) Worked with Communications on article for Treatment for Children with ADHD to educate members on ADHD to be included in the Medi-Cal Member Newsletter Spring 2023 edition 3) Met with PHM and recieved training on the process to send out text messages to members; drafted 2- way Text Message Script	1) Continue member outreach for those who filled an initial ADHD prescription 2) Pull report to identify trends in compliant and non-compliant providers 3) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 4) Treatment for Children with ADHD to be included in the Medi-Cal Member Newsletter Spring 2023 Ed.	
Quality of Clinical Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	Nathalie Pauli	PR HEDIS Rates Q1 (February): M/C: 26.89% OC: N/A 1) Barriers: No data 1st quarter from ITS Data Warehouse Team 2) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script	1) Continue to work with ITS for Q1 data 2) Identify members in need of diabetes screening test and their prescribing providers 3) Remind prescribing [roviders of best practice, provide list of members to complete screening with PCP contact information for each member to promote coordination of care 4) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7 day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Jeni Diaz	PR HEDIS Rates Q1 (February): 30 day- 19.42%, 7 day- 13.02% 1) Received Training from CalOptima Health vendor to recieve real-time Emergency Department (ED) data from local participating hospitals in Orange County 2) Idenified process to pull and review real-time ED data from vendor 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) BHI and QA devleop process to share real-time ED Data with Health Networks	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Valerie Venegas	PR HEDIS Rates Q1 (February): 30 day- 17.48%, 7 Day Total- 9.31% 1) Received Training from CalOptima Health vendor to recieve real time ED data from local participating hospitals in Orange County 2) Idenified process to pull and review real-time ED data from vendor 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) BHI and QA will devleop process to share real-time ED Data with Health Networks	
Quality of Clinical Care	Depression Remission or Response for Adolescents and Adults (DRR-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening, treatment, and follow up 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow-up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	Mary Barranco/Alvin Ortin	PR HEDIS Rates Q1 (February): N/A; Not at risk for meeting the standard due to no benchmark set 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data 2) Completed provider fax blast document encouraging screening for depression and best practice guidelines with member educational material on Understanding Depression 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script 4) Submitted Understanding Depression article for OneCare (OC) and Medi-Cal Member Newsletter Fall 2023 edition	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) Collaborate with Communcations to finalize article for Member Newsletter Fall 2023 Ed. 3) Distribute provider fax blast	

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Quality of Clinical Care	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening and treatment 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	Mary Barranco/Alvin Ortin	PR HEDIS Rates Q1 (February): N/A; Not at risk for meeting the standard due to no benchmark set 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data 2) Completed provider fax blast document encouraging screening for depression and best practice guidelines with member educational material on Understanding Depression 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script 4) Submitted Understanding Depression article for OC and Medi-Cal Member Newsletter Fall 2023 edition	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) Collaborate with Communcations to finalize article for Member Newsletter Fall 2023 Ed. 3) Distribute provider fax blast	
Quality of Clinical Care	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	Melissa Morales	1)Member Incentive: MC A1C Test: 19 approved, 2 denials, 2) Member Engagement: Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 Social Media (Passive): Social Media (Paid): Diabetes in January Digital Ad: Diabetes in January Radio: Diabetes January Provider Press: encourage members for A1c testing sent March to 2910 providers. 3) PR Report February 2023 HbA1C <8 Total (HBD): MC: Num 4,801/ Den 43,251 = 11.10% OC: Num 528/ Den 3,707 = 14.24% HbA1c>9 Total (Poor Control) (HBD): MC: Num 37,427/ Den 43,251 = 86.53% OC: Num 3,088/ Den 3,707 = 83.30%	2) Member, Community and Provider Engagement IVR: slated for Q3 2023/Q4 2023 Text: **Scheduled for May.** Will go to 10,136 Medi-Cal members.	
Quality of Clinical Care	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	Melissa Morales	1) Member Incentive: MC Eye Exam: 38 approved, 4 denials 2) Member Engagement Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 Social Media (Paid): Diabetes in January Digital Ad: Diabetes in January Radio: Diabetes January VSP Eye Exam Reminder Letters: MC Total sent in Q1 2023: 1,276, OC Total sent in Q1 2023: 533 3)PR Report February 2023 Eye Exam for Patients with Diabetes (EED): MC: Num 9,967/ Den 43,251 = 23.04% OC: Num 1,140/ Den 3,707 = 30.75%	1) Member Incentive OC slated for distibution mid/late May 2023 2) Member, Community and Provider Engagement IVR: slated for Q3 2023/Q4 2023 Text: **Scheduled for May.** Will go to 10,136 Medi-Cal members.	
Quality of Clinical Care	Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	Nicki Ghazanfarpour/ Jocelyn Johnson/Elisa Mora	Finalized member stratification in Jan 2023. Presented the pilot project status to QIC in Mar 2023. Began outreach to high volume PCPs in Q1. <u>Challenge</u>: Most high volume PCPs are FQHCs, and they already have a Clinical Pharmacist, a Health Educator or a multidisciplinary team to care for their patients with uncontrolled diabetes. Unable to launch the pilot program in Q1.	Continue outreach to CCN PCPs and look for partnership. Present the program at the June CCN Lunch & Learn to attract potential partners. Aim to launch the pilot - end of Q2/early Q3.	
Quality of Clinical Care	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP) Care Management, Comprehensive Diabetes Care (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	Linda Lee	Helen Syn	Analyzed measures and prioritized SNP Care Management, HbA1c Control, and COA for intervention. Interventions assigned to business owners and quality initiatives for implementation	Quality initiatives team and business owners to implement and monitor monthly.	
Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	Leslie Martinez	1.Postpartum Member Incentive: 143 submissions, all approved. 2. Community partnerships: WIC, OC Perinatal Council, First 5 OC, OC Health Care Agency, OC Home Visiting Collaborative, OC Family Task Force. Presented Doula Benefit at 2 community collaborative groups. 3. Member engagement: - Bright Steps Program: 916 new PNRs, 343 Postpartum Assessments completed, 732 total unique outreaches to members. - Community events: Baby Shower Educational Event planned for Q2. 4. W30 Data Workgroup: Early Identification and Data Gap Bridging Remediation for early intervention. - Working to identify data sources for the early identification of pregnancies for member engagement. **February 2023 Prospective Rates:** Timeliness of Prenatal Care: Reporting issues with current rate on the latest PR report. Rate for this measure to be reported on next quarterly updated. Postpartum Care: Performing higher than last year in February 2022, but MPL not met. Rate: 55.999%, MPL Rate: 77.37%	1. Planned: Member engagement once data source is established to identify members: - Mailing (planned) for the promotion of postpartum care once data source is established to identify members. - Medi-Cal member newsletter article, slated for Q2. 2. Provider Engagement: - Provider Press Newsletter, slated for Q2 to promote Medi-Cal enrollment and postpartum Care.	
Quality of Clinical Care	MCAS Performance Measures Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	Michelle Nobe	Well-Child Visits in the First 30 Months (W30-2+) PDSA Cycle 1: 11/4/22 - 3/17/23 SMART AIM Goal 1: By 02/28/2023, complete a minimum of 2 outreach call attempts, which includes both unsuccessful-unanswered calls and successful-answered calls by parent or guardian, to at least 90% of members (N=319) on the target list. Intervention Implementation Period: 2/1/23 - 2/10/23. Telephonic call campaign completed by 2 staff members, in-house. Outcomes: The results of this interventions indicated that 100% (313/313) of members were outreached at least 1 time, and 55.27% (173/313) of members were outreached at least 2 times. In order to meet the SMART AIM Goal there should have been at least 564 call attempts, but overall there were only 486. Therefore, the SMART AIM Goal 1 was not met. However, it was also evident that a 2nd attempt was not indicated in instances due to disconnected/wrong phone number/member refusal. Submitted Cycle 1 to DHCS: 3/23/23.	Well-Child Visits in the First 30 Months (W30-2+) PDSA 1) Proceed with Cycle 2: 3/24/23 - 7/14/23. Cycle 2 intervention will include in-house telephonic call campaign and a birthday card mailer.	

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Quality of Clinical Care	Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	Michelle Nobe	1) Targeted member engagement and outreach campaigns in coordination with health network partners. - Met with Health Networks to share Quality Initiatives Activities Calendar for CY2023 **2) Strategic Quality Initiatives Intervention Plan** - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. - Well-Child Visits 0-30 Months Text Message Campaign (2/22-2/28/23): 8,183 messages sent, 152 members responded to text message; Well-Care Visits 3-17 Years Text Message Campaign (2/28-3/11/23): 72,870 messages sent, 3,887 members responded to text meesage; Plans to expand Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up. 2-weeks high priority and 3-months old outreach calls are continued; IVR scripts are in development Updated and/or created artwork for the following: - Health Guide 0-2 Years Newsletter with Blood Lead Screening; Health Guide 3-6 Years Newsletter; Health Guide 7-12 Years Newsletter; Health Guide 18-21 Years Newsletter; Well-Child Visits Flyer Newsletter; First Birthday Card + Second Birthday Card. Artwork is complete and dashboard is developed. Working with Procurement to set up a monthly mailing cadence. **3) Early Identification and Data Gap Bridging Remediation for early intervention.** W30 Data Strategies Workgroup: - Improved HN monthly Gap Reports to include more measures and details - Developing W30 Gap Report for HNs. Will pilot with 1 HN in Q2 for feedback. **4) February 2023 Prospective Rates** CIS-Combo 10: 21.58%, performing lower than last year (2.72%), have not met goal (49.76%) IMA-Combo 2: 33.99%, performing lower than last year (35.45%), met the 33rd percentile, have not met goal (48.42%) W30-First 15 Months: 15.56%, performing better than last year (8.12%), have not met goal (55.72%). +7.44% improvement W30-15 to 30 Months: 51.96%, performing better than last year (46.87%), have not met goal (69.84%) WCV (Total): 2.50%, performing better than last year (2.20%), have not met goal (57.44%)	1) Continue targeted member engagement and outreach campaigns in coordination with health network partners. 2) Continue with Strategic Quality Initiatives Intervention Plan. - Well-Child Visits 0-30 Months Text Message Campaign, slated for May - Well-Care Visits 3-17 Years Text Message Campaign, slated for June - Implement Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up starting late April. - IVR scripts 1) W30: 0-14 months, 2) W30: 15-30 months, 3) WCV 3-17 years, and 4) WCV 18-21 Years scripts to be recorded in Q2. Tentative launch for W30 IVR campaigns in May-June. Mailings: - Health Guide 0-2 Years Newsletter with Blood Lead Screening, slated for April - Health Guide 3-6 Years Newsletter, slated for Q2 - Health Guide 7-12 Years Newsletter, slated for Q2 - Health Guide 18-21 Years Newsletter, slated for Q2 - Well-Child Visits Flyer Newsletter - First Birthday Card, slated for late April and June - Second Birthday Card, slated for late April and June 3) Continue efforts for early Identification and Data Gap Bridging Remediation for early intervention. W30 Data Strategy Workgroup plans to come up with recommedation to present at May BOD.	
Quality of Clinical Care	Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	- PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. - Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education - Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, - Launch IVR campaign to members with untested children - Member mailing campaign to members - Lead texting campaign for members - Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	Leslie Martinez	1. Policy GG.1717 updated to include attestation process for Health Networks and CCN providers to attest to operational and regulatory requirements for lead which include: documental of blood lead refusals, proper coding, provision of anticipatory guidance, following standards of care for lead testing. 2. PBS television ad campaign conducted in February and March 2023 to advise parents/guardians that a lead test is the only way to identify lead exposure. Total impressions: February 2023 = 20,390; March 2023= 9,439. 3. Anticipatory Guidance and Blood Lead Refusal form that was developed in house to support providers with documentation of blood lead refusals and anticipatory guidance was posted on the CalOptima Health Website along with Clinical Practice Guidelines. 4. IVR campaign launched in March 2023. Population approach was used to target members within the age ranges of a lead test. IVR left message or successfully played message to 3,801 members. 5. Provider Education via Provider Monthly Update to inform providers of operational and regulatory requirements pertaining to blood lead testing. 6. Provider Portal enhancements completed to include a blood lead screening dasbhoard to display quarterly reports for CCN providers, alerts for attestations. 7. Email alerts created for CCN Provider Portal users to be advised of the availiability of new blood lead reports. 8. Blood Lead Screening Guide developed for Provider Portal users that outlines regulatory requirements for lead, steps for accessing quarterly blood lead reports and completing attestations on the Provider Portal, resources for lead testing, etc. **February 2023 Prospective Rates:** Currently performing higher than last year in February 2022, but has not met MPL. Rate: 53.97%, MPL rate: 63.99%.	- Mailing (in progress): Health Guide 0-2 Years Newsletter with - - Blood Lead Screening, slated for Q2. - Lead texting campaign for members slated for April 2023. - Medi-Cal member newsletter article, slated for Q2. - Improvement of blood lead quarterly reports to align with standards of care for lead testing, slated for Q3. - Development of outreach report to proactively identify members that will be due for a 12 and 24 month blood lead test. - Provider Press article slated for Q3. - Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up with blood lead testing education, slated for April 2023.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) Actively recruit top 3 out-of-network (OON) specialties as shown on QMRT 2) Targeted outreach campaign and incentive to open their panels 3) Business consideration to require providers to participate in all programs. 4) Provider incentive for transportation vendor	by end of 4Q, 2023	Marsha Choo		Provider/HN workgroup has been created to focus on expanding the network. The worgroup has met twice to review data on the following provider types: PCPs and impacted specialists: cardiology, GI, pulmonology (tier 2- Neuro, Rheum, Urology	Workgroup will determine if lower ratios or increased use of physician extenders is needed for these provider types.	
Quality of Service	Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Marsha Choo		Planning to begin in Q3, pending budget.	Draft scope of work and pull universe to faciliate 2023 Timely Access survey.	
Quality of Service	Improve Access: Telephone Access	Live Contacts Rate After 3 Attempts to meet 80%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	by end of 4Q, 2023	Marsha Choo		1. Providers/HNs have met compliance for provider directory validation and have provided provider's attestations timely overall. 2. Assigned HNs to follow-up with providers who recieved a 2nd year notice of non-compliance for educational purposes.	1a. Continue to work closely with all HNs to ensure directory validation accuracy continues to progress as needed. 1b. HN will evaluate their process and workflow to improve communications with providers as needed. 2. Continue to monitor and educate.	
Quality of Service	Improve Access: Access Dashboard	Develop an access dashboard for HN performance	1) Identify access measures to include in performance monitoring 2) Develop a methodology to monitor performance	by end of 2Q, 2023	Marsha Choo		Provider/HN workgroup has been created to focus on expanding the network and a dashboard templatehas been created for this workgroup to track accomplishments, milestones and outcomes.	Workgroup is working towards implementing initiatives to expand the network and will utilize the draft dashboard template to report to committee.	
Quality of Service	Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access	by end of 4Q, 2023	Marsha Choo		Complete SNC submission to DHCS for the four elements and is now under review with Enterprise PMO. All HNs met Provider to Member Ratios and CCN is the only HN to meet Time/Distance for Medi-Cal LOB.	Finalize SNC submission and submit by end April.	
Quality of Service	Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	Anna Safari	1. PHM presented at the Feb. Health Network Forum, three Joint Operations Meetings, and the March CCN Provider Lunch & Learn. 2. Obtained DHCS approval on IHA IVR campaign, established automated reports with ITS, IVR Call Campaign to launch Q2.	Update provider reference guide with current IHA codes, update IHA table logic with ITS to exclude specialists from universe, update reports with ITS to create actionable information for providers in portal.	
Quality of Service	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	1) by end of 4Q2023	Linda Lee	Javier Sanchez	Analyzed measures and prioritized CAHPS composites and overall ratings. Interventions assigned to Stars/CAHPS work groups for implementation. TTY/Foreign language interpreter monitored by Stars/CAHPS Customer Service work group.	Stars/CAHPS work groups underway- five work groups (provider, medical management, pharmacy, customer service, and member material development) began on 4/14/2023. Work groups will meet weekly and report bimonthly to Steering Committee.	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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 Service	Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Marsha Choo	Carol Matthews	1) The RFI was converted to a RFP. An enjoined RFP with the Member Engagement Platform was issued 3/23/2023 with proposals due 4/25/23.	1) Evaluation meeting scheduled 5/4/2023 with the goal of a vendor award on 5/29/2023.	
Safety of Clinical Care	Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Michelle Findlater	Scott Robinson	Data shows that 177 Unique members were seen in the ED during the pilot timeframe. The data from these members was tested against a control group of 2,515 who visited the St. Joseph's during the months of November and December 2022 who did not participate in the Pilot program. 1.The members included in the ED Diversion pilot have much higher ED utilization (both prior and post ED visit at St. Joseph's) than the control group. In the six months prior to the St. Joseph's DOS, members included in the pilot program had an average of 1.39 ED visits PMPM compared to 0.18 ED visits PMPM for the control group. Similarly, in the 30 days post-DOS, members included in the pilot program had an average of 1.56 ED visits PMPM compared to 0.32 ED visits PMPM for the control group. 2.The members included in the ED Diversion pilot program have much higher ECM enrollment in comparison to the control group. Prior to the St. Joseph's ED Visit, 5.08% of the members in the pillot program were enrolled in ECM compared to only 0.28% of the control group. In the 30 days post ED visit, 29.38% of the members in the pilot were enrolled ECM compared to only 0.08% of the control group. However, many of the members from the pilot who were enrolled in ECM did not stay enrolled. 39 of the 52 members from the pilot enrolled within 30 days are not currently enrolled in ECM. Today, 10.73% of the pilot members are enrolled in ECM compared to 0.32% of the control group. 3.The ED Diversion pilot had a much higher percentage of members identified as potentially eligible for a POF (in particular POF #2, High Utilizers). In the POF identification run immediately proceeding the ED visit at St. Joseph's, 48.02% of the pilot members were identified as potentially eligible for a POF while only 12.29% of the control group was. In the most recent POF identification run, 64.97% of the pilot members were identified as potentially eligible for a POF while only 14.91% of the control group was. 4.The ED Diversion program had a higher percentage of members with a CS authorization within 30 days of DOS than the control group. There was an CS authorization for 12.99% of the pilot members compared to only 1.71% of the control group.	The ED Pilot program at St. Joseph's is now officially complete. Next steps in the program will be to transition the program to a virtual model. This will be executed by a combination of LTSS, CCR and Prior Auth staff members. The plan is for direct communication to occur with the focus transitioning to safe and expeditious discharges. The CalAIM referral process will fall back to the staff in the ED the referral forms as appropriate and not for the CalOptima Health Staff to complete them on the member's behalf. The CalOptima Health staff will maintain a log of all members who participated in the program so that there can be data pulls at designated intervals in the future.	
Safety of Clinical Care	Plan All-Cause Readmissions (PCR)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by ~~1~~0.5% each quarter (focus on getting discharge plans w/ PCP appt from hospitals)	Planned Activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	***Setting up the workgroup*** – Not met: There has been a TCS Workgroup established to discuss TCS requirements outlined in the PHM Guide. However, it was noted that the TCS Workgroup was not the most suitable forum to discuss strategies to increase post hospital visits with the PCP. Therefore, we plan to set up a separate Transitions of Care Workgroup dedicated to post discharge PCP visit by the end of Q2 2023. ***Updating the UTC letter*** – Met: The post discharge UTC letter has been approved and is now available in GuidingCare. The post discharge CM DTP has been also updated to reflect that new letter when a member is unable to be reached post hospitalization. Clinical Operations also developed a Hospital Memo for hospital partners.	Set up a separate Transitions of Care Workgroup dedicated to post discharge PCP visit by the end of Q2 2023. The goals/reporting metrics are still pending; continue defining the goals/metrics by Q3 2023.	

Board of Directors' Quality Assurance Committee (QAC) Meeting
June 14, 2023

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
First Quarter 2023 Meeting Summaries

February 21st, 2023: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary Health Plan Monitoring Data and PACE Quality Initiatives

- All PQIC members present.
- Infection Control Subcommittee: PACE's Response to COVID-19:
    - Staff and participants continue to wear mask inside the PACE center and clinic.
    - PACE Staff to report exposure/illness to their supervisor and HR. And reminded not to come in if feeling sick.
    - PACE staff must be fully vaccinated + booster or exemption.
    - Participants must also have their COVID vaccine and booster to attend day center. Currently capacity is 60 per day but averaging 54 per day. Participants continue to be in separated cohorts with assigned PCAs.
    - At the end of Q3, Bivalent vaccines were introduced.
    - During Q4 2022 the following # of participants were vaccinated with bivalent vaccine:
        - October 2022- 150 received doses, thanks in part to nurse from ExcelCare coming to PACE and giving shots directly at PACE.
        - November 2022- 14 received doses.
        - December 2022- 44 received doses.
    - Continue to monitor and track the vaccine status of all participants, to include who has needs bivalent, who has refused and who needs scheduling and/or transportation assistance.
    - Q4 has a total of 30 cases, all recovered. No death or hospitalization reported.
    - All new cases of COVID reported to CalPACE, NPA, and CMS and telehealth follow up by providers (PCP f/u on symptom improvement and O2 levels).
    - Treatment- Paxlovid oral antiviral when appropriate.
    - DHHS extended the COVID 19 Public Health Emergency until 4/11/23.
        - Shifting of costs for COVID-19 vaccination and testing
        - Raise in the price of medication Paxlovid.

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        - Special waivers for Medicaid and Medicare requirements that have been in place throughout the pandemic will also come to an end when the public health emergency expires.
    - Weekly COVID 19 updates in Leadership meetings and monthly updates during All-Staff meetings.
    - Continue to follow State and local guidance regarding COVID safety updates.
- Presentation of Q4 2022 HPMS Elements:
    - Membership. Figures presented. Increased in terms of total membership. Q4 ended with 434 total enrolled, an increase of 2 from Q3. Goal of 474 was not met.
    - Immunizations
        - Pneumococcal Immunization rate is at 86%. 375 received, 29 prior immunizations, 16 refused and 14 missed opportunities.
        - Influenza Immunizations rate is 93%. 403 received, 13 no immunization and 18 refused.
        - Covid-19 Immunizations is at 98%. Goal of 95% has been met.
    - Falls without Injury. Q4 ended with 60. An increase from 51 in Q3. Center manager noted that the trend shows the colder months we see more falls. Rehab started to do the environmental checks for multiple falls, suggesting repositioning, cleaning the area, and providing some DME.
    - Grievances. Increased from 7 in Q3 to 8 in Q4. 3 were transportation related, 3 related to contracted Specialist and 2 were miscommunication. In 2023, starting quality initiatives for transportation satisfaction.
    - Emergency Room Visits. 71 ER visits, a decrease of 14 in Q3. 26 were d/c to home without hospital admission. 45 admitted to hospital (5 for observation only). Trends in admission diagnoses: Sepsis/Pneumonia/Viral Infection, Pulmonary Disease or Respiratory Failure and Heart Failure. Other common admission diagnoses include- Syncope and collapse, fractures, dizziness, and giddiness, altered mental status.
    - Medication Error Without Injury. No Medication Error in Q4.
    - 2022 Q4 HPMS Quality Indicators
        - Enrollment Data - 434
        - Immunizations – Pneumococcal, COVID-19
        - Falls Without Injury- 60
        - Denials of Prospective Enrollees - 0
        - Appeals - 0
        - Grievances- 8
        - Emergency Room Visits- 71

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        - Medication Administration Errors - 0
        - Quality Incidents- 11
    - Quality Incidents with RCA
        - Falls with Injury – 6
        - Elopements – 1
        - Burn – 2
        - Pressure Ulcer - 0

- Presentation of Q3 2022 PACE Quality Initiative Data
    - COVID-19 Vaccine Booster Quality Initiative.
        - Goal was 80% booster dose. 95% of eligible prts received a booster dose (3rd dose of vaccine). Goal Met. 4th doses, 5th doses, and beyond…
        - Starting 9/1/22, PACE has been helping participants to get the newly approved BIVALENT COVID vaccine. We continue to follow regulatory guidance regarding timing of vaccinations into 2023.
        - The Quality Initiative will be removed for 2023, however, we will be changing our quality element to look at Bivalent dosing moving forward.
    - Telehealth Engagement Quality Initiative.
        - Goal for 2022 is that ≥ 66% of members will be able to engage in telehealth visits by having telehealth access such as VSEE, Google Duo or Facetime capabilities. Currently at 57%. Increase of 6% from Q3.
    - Advanced Health Care Directive. Q4 ended 40%, goal is 50% by end of 2022.
        - This initiative focuses on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having completed AHCD in 2022.
        - Goal is ≥ 50% of members will have AHCD scanned into their chart. Q4 2022 ended at 40%. Though this initiative was not met Q4 2022, we will continue this initiative into 2023 and work is already being done to evaluate the ADHC forms and the process for completion.
            - Exclude those not enrolled for at least 6 months.
            - Exclude MME <16

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        - Focus are particiapnts attending DCA
    - New Quality Initiatives in 2023. 2 new Quality Initiatives for 2023, both with the goal of improving participant satisfaction with services and reducing grievances.
        - Dental Satisfaction Quality Initiative. This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a specialist outside of PACE, to find any areas of dissatisfaction that can be addressed in a timely manner.
            - Goal is ≤ 1 dental related grievance per quarter in 2023.
            - The main purpose of the questionnaire: To find out the problems before they become grievance and to address the problems immediately before they become grievance.
        - Transportation Satisfaction Quality Initiative. This initiative will focus on increasing the participant satisfaction with contracted transportation services, to provide participants with timely resolutions to transportation related issues that are in transportation log. PACE Center manager in conjunction with Secure transportation manager, PACE Clinic Manager, and PACE Clinical Support Services Supervisor will review and resolve all complaints received by PACE participants regarding PACE transportation in a timely manner.
            - Goal is ≤ 3 valid transportation related grievance per quarter in 2023.
            - *Timely pick up definition is + or – 15 minutes of scheduled time.

February 21st, 2023: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- All PQIC members present
- Presentation of the Quality Work Plan Elements
    - *Elements 3 – 5: Immunizations*

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- Influenza Immunization rate is at 93%. Goal of 94% was not met. In 2023 we will exclude participants with palliative care approach, Guillain Barre, and those with vaccine allergy from the data report.
- Pneumococcal Immunization rate is at 87%. Goal of 94% was not met yet. In 2023 we will exclude participants with palliative care approach, and those with vaccine allergy from the data report. In Q4 2023 report we will not include those who enroll in the month of December.
- Covid-19 Immunizations is at 98%. Goal of 95% has been met. 423 participants received the vaccination. In 2023 we will change this element to reflect the % of participants who have received the BIVALENT Booster dose. Goal is 80% by end of 2023. Exclusion are: Participants who enroll in the program in December 2023, Participants who have not already received initial doses of COVID-19 vaccine, and Participants who have recently tested positive for COVID-19 or at provider's discretion for appropriateness of vaccine dosing.

- *Element 6: POLST.* Goal is 95%. In Q4, 94% of participants have POLST added to their chart. Goal was not met. Goal was met in Q3 2022, but not in other quarters, although there was overall improvement from 2021. In 2023 we will continue to maintain the goal of 95% of participants having a POLST in their chart.
- *Elements 7 – 9: Diabetes Care.*
  - Blood Pressure Control. Goal is 81.50% having a blood pressure of <140/90mm. Rate is 71%. Goal of maintaining BP at <140/90 for >81.50% of our diabetic participants was not met in 2022. In 2023 this goal will increase to >84.21% to match with the updated Medicare Quality Compass HEDIS 95th percentile measure. We will now be excluding participants who have a diagnosis of Frailty (ICD-10 R54) to address that some participants may have better health outcomes when maintaining elevated but reasonable blood pressure levels vs. aggressive blood pressure treatment which could have detrimental effects.
  - Diabetic Eye Exams. Goal of 82.77%. Rate is 96%. Goal met. Goal of >82.77% of diabetic participants receiving eyes exams was met each quarter. In 2023 this goal will increase to >85.42% to match with the updated Medicare Quality Compass HEDIS 95th percentile measure. At this time PACE is in the process of potentially partnering with an optometrist to come to PACE and perform eye exams within the clinic.

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        - Nephropathy Monitoring. Goal is 98.30%, Rate is 100% in monitoring Diabetes patients. *Goal of >98.30% of diabetic participants receiving eyes exams was met each quarter. In 2023 this goal will increase to >98.78% to match with the updated Medicare Quality Compass HEDIS 95th percentile measure.
    - *Element 10: Osteoporosis Treatment.* Goal of 90%. Rate is 99% of participants with Osteoporosis receiving treatment. Goal of >90% of participants with Osteoporosis will be receiving treatment was met every quarter. This element will be changed in 2023 to reflect the need for Osteoporosis screening using DEXA scanning. The new goal will be that 100% of participants who experience a fall will have had a DEXA scan within the past 2 years and if not, they will have one within the next 6 months. Providers will ensure that they follow up on each fall report to confirm that each participant has been screened for OP.
    - *Element 11: Falls at Home classified as CMS Reportable Quality Incidents.* Falls those results in fracture, hospitalization, and death. Q4 ended with 6, with a Rate of 59, well below the Goal of <207 per 1000 prts per year. Goal of <207 per 1000 per year was met each quarter. This element was more shown to be more quantitative than qualitative and has been changed for 2023. The new goal is <72 falls reported per quarter in 2023 and will look specifically at reducing these fall numbers by reducing the number of repeat fallers. The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls. Participants who have repeated falls will have a documented home assessment scheduled rehab team (within one week of fall) and follow up completed by PACE to help reduce the total number of overall falls. Excluded are those who fall within a hospital or skilled nursing facility.
    - *Elements 12 - 13: Potentially Harmful Drug/Disease Interactions in the Elderly.*
        - Dementia - Goal is <27.24%. Rate is 19%.
            - Goal of <27.24% % of participants with Dementia will be prescribed a tricyclic antidepressant or anticholinergic agent was met every quarter. In 2023 this goal will increase to <24.64% to match with the updated Medicare Quality Compass HEDIS 95th percentile measure. Excluded are participants with Palliative Care Approach dx and those with schizophrenia or bipolar disorder.
        - CKD – Rate is 0%. Goal of <3.47% % of participants with CKD 3,4, or 5 (end stage) will be prescribed a Nonaspirin NSAIDS or

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Cox2 Selective NSAIDs was met every quarter. In 2023 this goal will change to <2.62% to match with the updated Medicare Quality Compass HEDIS 95th percentile measure. Excluded are participants with Palliative Care Approach dx and those who are prescribed topical NSAIDS such as Voltaren (Diclofenac) gel since they have minimal systemic absorption.

- *Element 14: Decrease the Use of Opioids at High Dosage.* Goal: 100% of members receiving opioids for 15 or more days at an average milligram morphine dose of (MME) 90mg will be reevaluated monthly by their treating provider.
  - Actual: Met goal. Only one participant received a dose greater than 90 MME and had PCP follow up each month in Quarter 4 2022.
  - In 2023 we will maintain this element, as prevention of opioid abuse and safe use of pain medication remains a continuing goal for our program.
- *Element 15: Medication Reconciliation Post Discharge (MRP)*. Goal is 90% within 15 days. Rate is 96%. In 2023 this goal will be changed to strive for additional improvement in timely reconciliation. The goal will now be for 90% of medication reconciliation to before completed within 10 days of discharge. Additionally, we will now include med reconciliation after discharge from skilled nursing to home in our data set.
- *Element 16: Access to Specialty Care.* Goal is ≥ 85% to be scheduled within 14 business days. 90% in Q4 2022. Goal was met each quarter in 2022. In 2023 this goal will be changed to strive for additional improvement in timely specialty care for our participants. The goal will now be for 88% of appointments for specialty care will be scheduled within 14 business days to improve access to specialty care.
- *Element 17: Telehealth Access.* Goal is >=66%. Rate is 57%. There was an improvement from Q3 but still did not meet the goal for 2022.
- *Element 18: Acute Hospital Days.* Goal was raised to <3,330 in 2022. Goal was not met. In Q4, bed days increased from 4412 to 4426. Quarterly Rate of Bed Days decreased from 989 (Q3 2022) to 964 (Q4 2022). In 2023 we will exclude from the data anyone who had a Long term hospitalization of >90 days.
- *Element 19: Emergency Room Visits.* Rate is 810. Below the goal of 850 emergency room visits per 1000 per year.
- *Element 20: 30-Day All Cause Readmissions.* Goal is <14%. Rate went up from 19% to 23% Goal was not met.
- *Element 21: Long Term Care Placement.* Goal is <4%. Rate is 3.69 in Q4. Goal met. Long Term Care Placement are prts placed in custodial care in

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SNF in any period. Only Monica and Dr. Frisch are allowed to make decisions on who will go to custodial care and we will utilize CalOptima Health's long-term support service department as well.

- *Element 22: Enrollment Conversion*. Goal is 60%. Rate is 73%. Goal met. In 2023, this goal will be changed to >65%. Another element will be added in 2023 that 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%. An additional element will look at overall attrition from the program with a goal to maintain an attrition rate of ≤10 %
- *Element 23: Transportation <60 minutes.* Based on the data from Secure, there was 1 violation.
- *Element 24: Transportation on Time Performance.* On time performance data gathered directly from Secure transportation report to reflect on time trips with a +/- 15-minute window. Goal is ≥92% of all transportation rides will be on-time. 98% in October, 90% in November and 94% in December.
- *Element 25: Transportation Satisfaction.* Satisfaction with transportation declined in 2022, 7 percentage points below the previous year and below the national average for 2022. Despite this, 89% of participants surveyed stated that van service was Good to Excellent. In 2023 we will raise our goal to ≥93.6% to compare with 2022 National PACE averages. Our 2023 Quality Workplan also includes a Quality Initiative to address participant concerns with transportation to raise satisfaction and reduce grievances.
- *Element 26: Meal Satisfaction.* In 2021, rate was 80% and increased to 82% in 2022. 2022 National PACE average is at 71.1%.
- *Element 27: Overall Satisfaction.* The overall weighted score in 2021 was 91% and 89% in 2022. Overall Satisfaction declined somewhat in 2022, but still meeting our goal of maintaining the National PACE average of 88.6% or above.

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Member Trend Report 1st Quarter 2023

Quality Assurance Committee Meeting

June 14, 2023

Tyronda Moses, Director, Grievance and Appeals

Our Mission

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

Our Vision

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

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Overview of Presentation

- Definitions
- Grievances by Line of Business
  - Per 1,000 Member Month (M/M)
  - Trends
- Appeals Summary
- Summary of Trends and Remediations

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CalOptima Health

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

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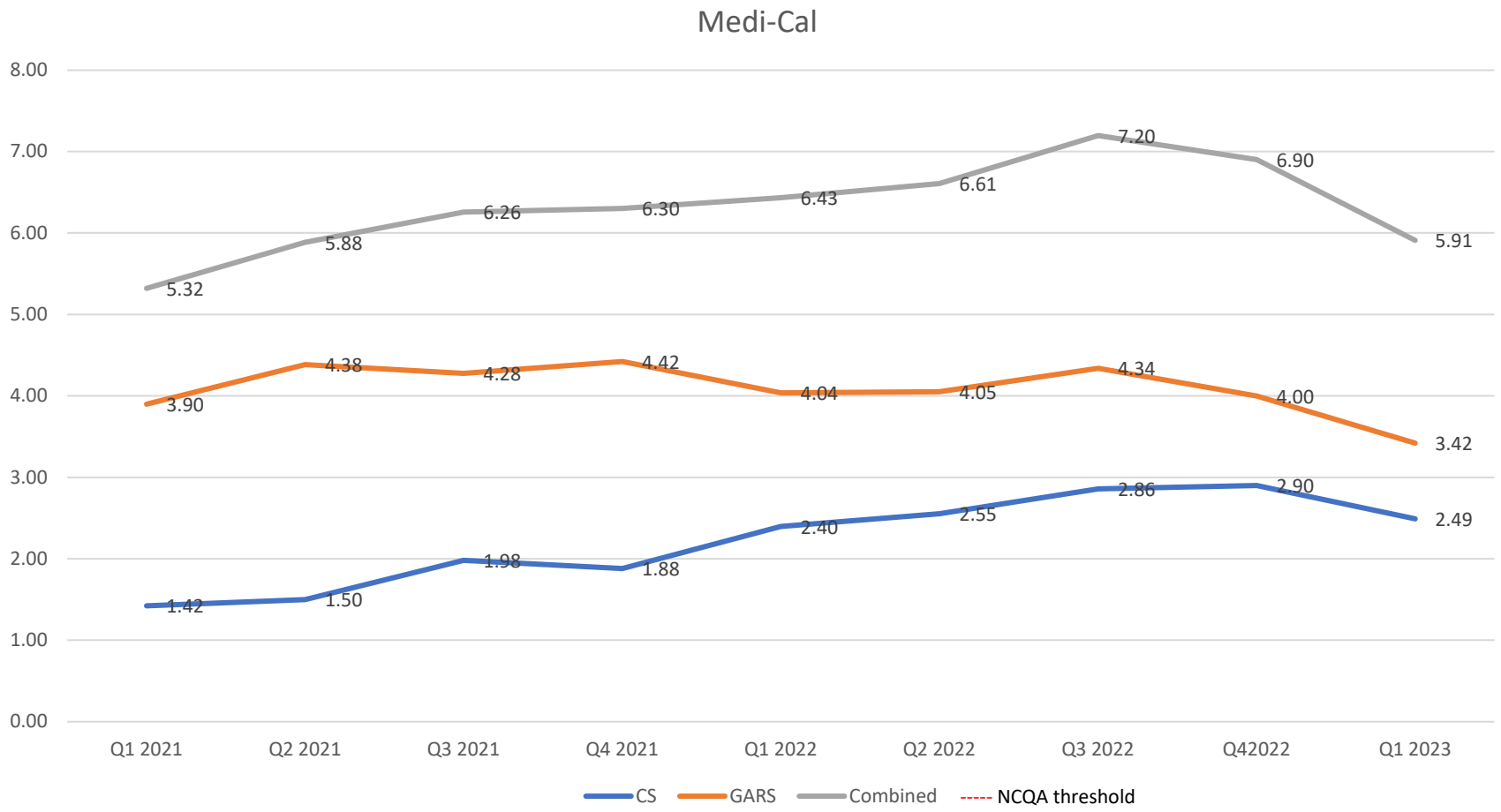
CalOptima Health

Medi-Cal Grievances Rate per 1000



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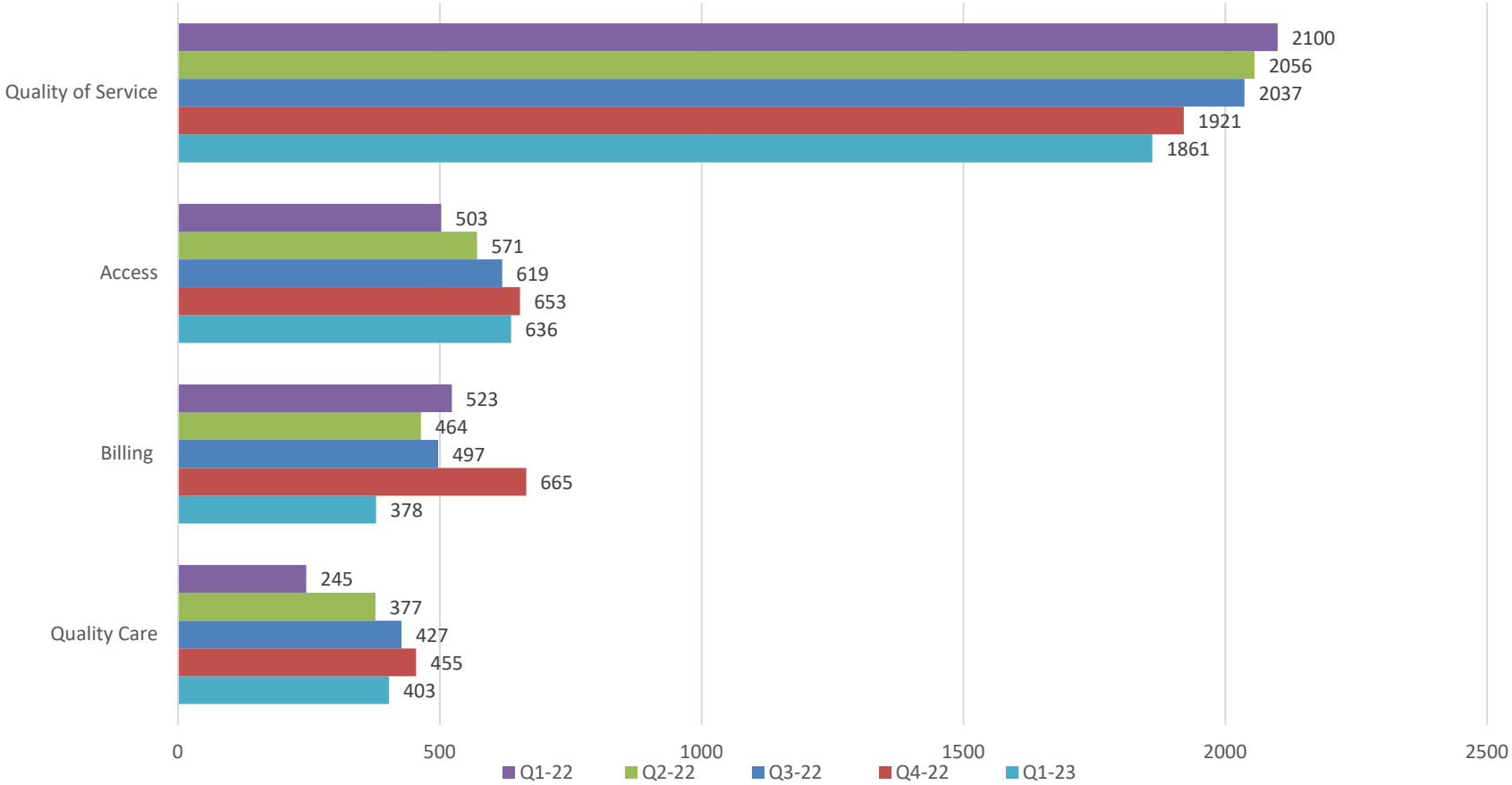
Medi-Cal
CalOptima Health

Medi-Cal Member Grievances by Category



Quality of Service – Transportation (251)
Access – Appointment Availability (187) and Telephone Accessibility (102)
Billing – Member Billing-HN (165)
Quality of Care – Question in Treatment (160)

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Medi-Cal
CalOptima Health

Medi-Cal Member Grievances

	Billing & Financial 12%	Quality of Care 12%	Quality of Service 57%	Access 19%			
Health Network	Q1	Q1	Q1	Q1	YTD Total	Membership Average	Rate per 1000
AltaMed	11	26	64	27	128	67,178	1.91
AMVI	3	4	6	7	20	29,883	0.67
Arta	9	20	68	25	122	66,553	1.83
CCN	69	141	470	196	876	131,674	6.65
CHA	18	29	58	28	133	163,398	0.81
COD	33	15	109	30	187	131,066	1.43
Family Choice	5	10	30	7	52	48,870	1.06
Heritage	2	5	24	6	37	8,823	4.19
Kaiser	114	21	341	67	543	59,723	9.09
Monarch	71	70	283	134	558	106,282	5.25
Noble	1	4	20	8	33	22,436	1.47
Prospect	10	17	44	27	98	44,536	2.2
Talbert	15	15	47	18	95	33,348	2.85
UCMG	8	6	34	17	65	45,661	1.42
Plan Provided							
Behavioral Health	9	17	46	38	110	959,430	0.11
Veyo, LLC	0	3	217	1	221	959,430	0.23
Grand Total	378	403	1861	636	3278	959,430	3.42

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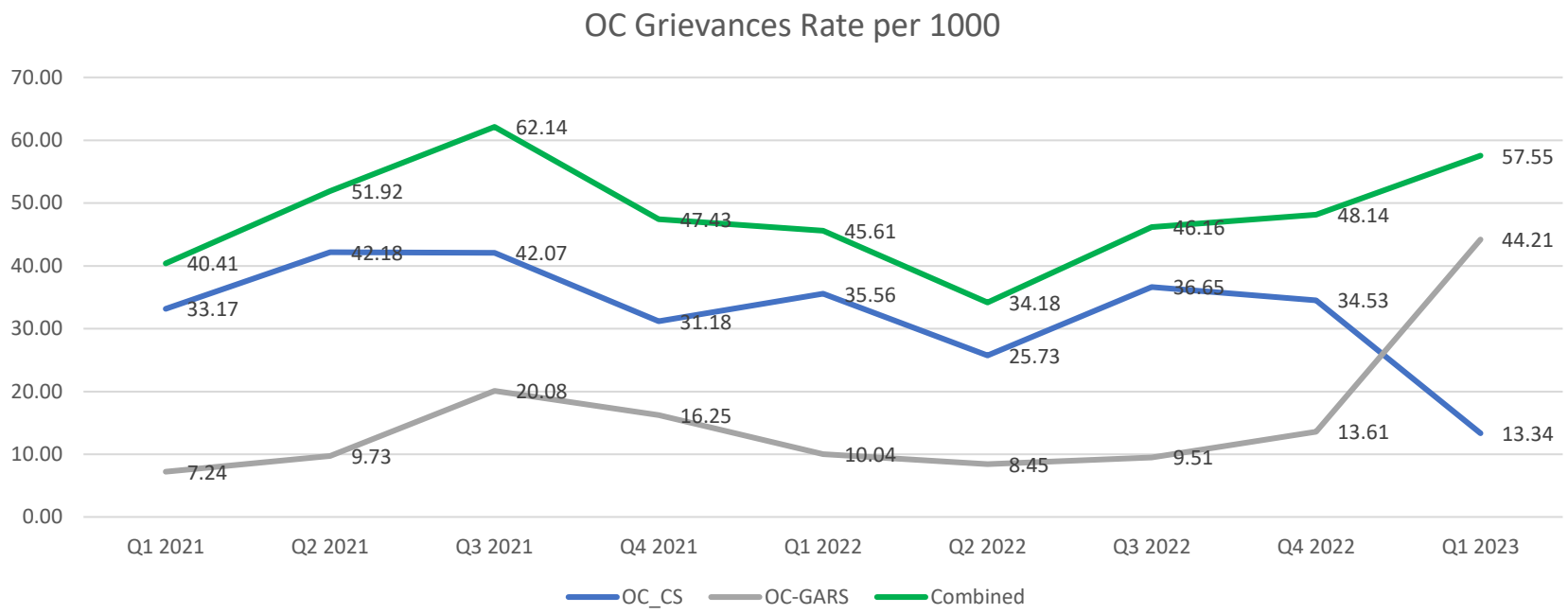
Medi-Cal
CalOptima Health

OneCare Grievances



Quarter	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023
OC_Customer Serv. r/1000	33.17	42.18	42.07	31.18	35.56	25.73	36.65	34.53	13.34
OC-Customer Serv. Ct	55	78	88	71	85	67	104	104	232
OC-GARS r/1000	7.24	9.73	20.08	16.25	10.04	8.45	9.51	13.61	44.21
OC-GARS Ct.	12	18	42	37	24	22	27	41	769
Combined r/1000	40.41	51.92	62.14	47.43	45.61	34.18	46.16	48.14	57.55
Combined Ct.	67	96	130	108	109	89	131	145	1001

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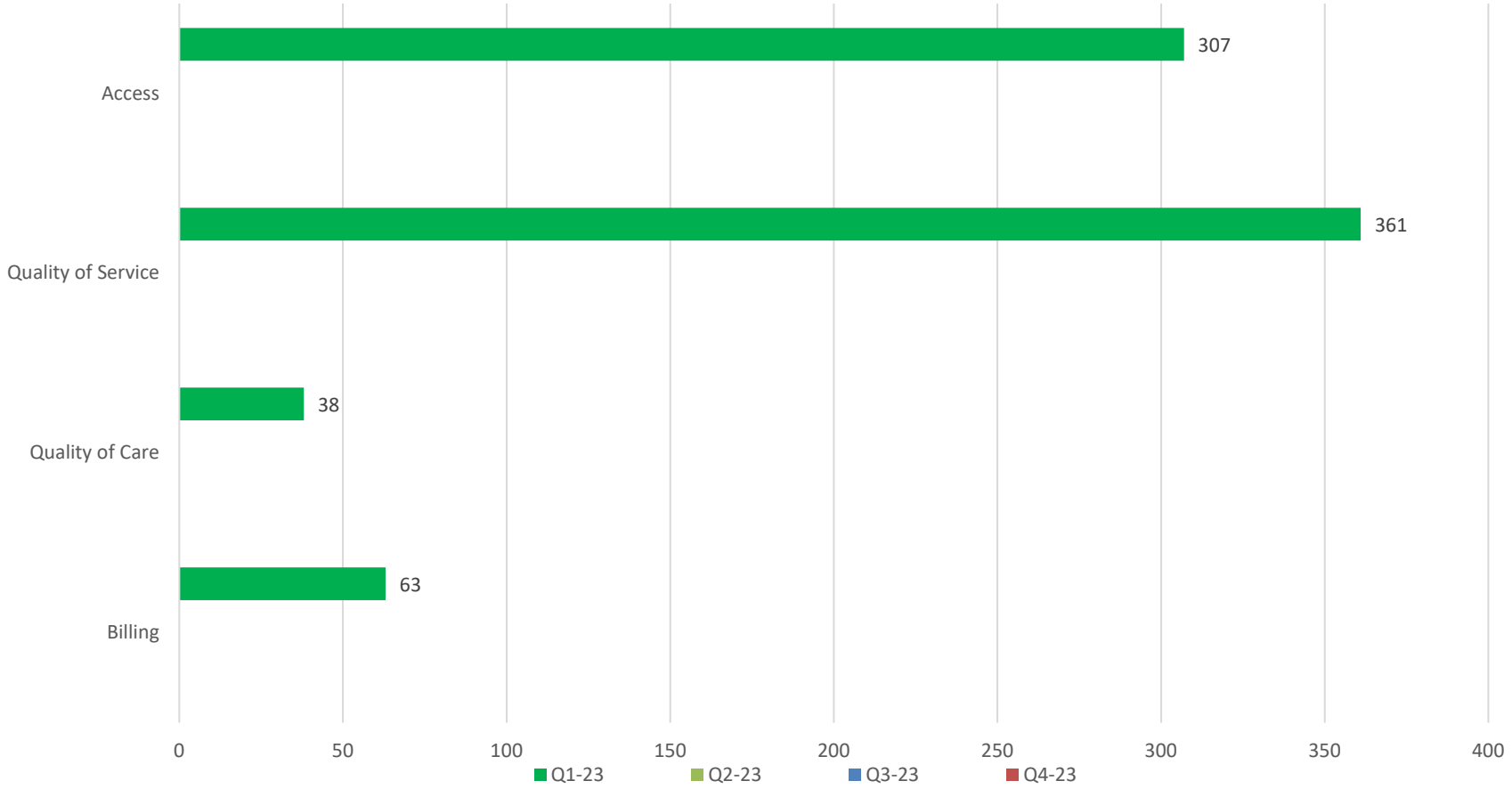
OneCare CalOptima Health

OneCare Member Grievances by Category



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OneCare CalOptima Health

OneCare Member Grievances

	Billing & Financial 8%	Qualtiy of Care 5%	Quality of Service 47%	Access 40%			
Health Network	Q1	Q1	Q1	Q1	YTD Total	Membership Average	Rate per 1000
AltaMed	3	3	6	11	23	921	25
AMVI	1	0	3	3	7	404	17.3
Arta	2	2	7	6	17	862	19.7
CCN	23	7	45	42	128	2,407	49.2
Family Choice	4	0	8	16	28	1,954	14.3
Monarch	20	14	85	86	205	5,669	36.2
Noble	3	1	1	5	10	365	27.6
Prospect	5	5	35	38	83	2,394	34.7
Regal	0	0	1	1	2	223	9
Talbert	1	3	20	27	51	1,416	36
UCMG	0	1	2	7	10	772	13
Plan Provided							
Behavioral Health	0	0	0	0	0		0
Convey Health	1	0	16	34	51		2.9
Silver and Fit	0	0	1	14	15		0.9
VSP	0	1	3	1	5		0.3
Veyo, LLC	0	1	122	11	134		7.7
Grand Total	63	38	361	307	769	17,394	44.2

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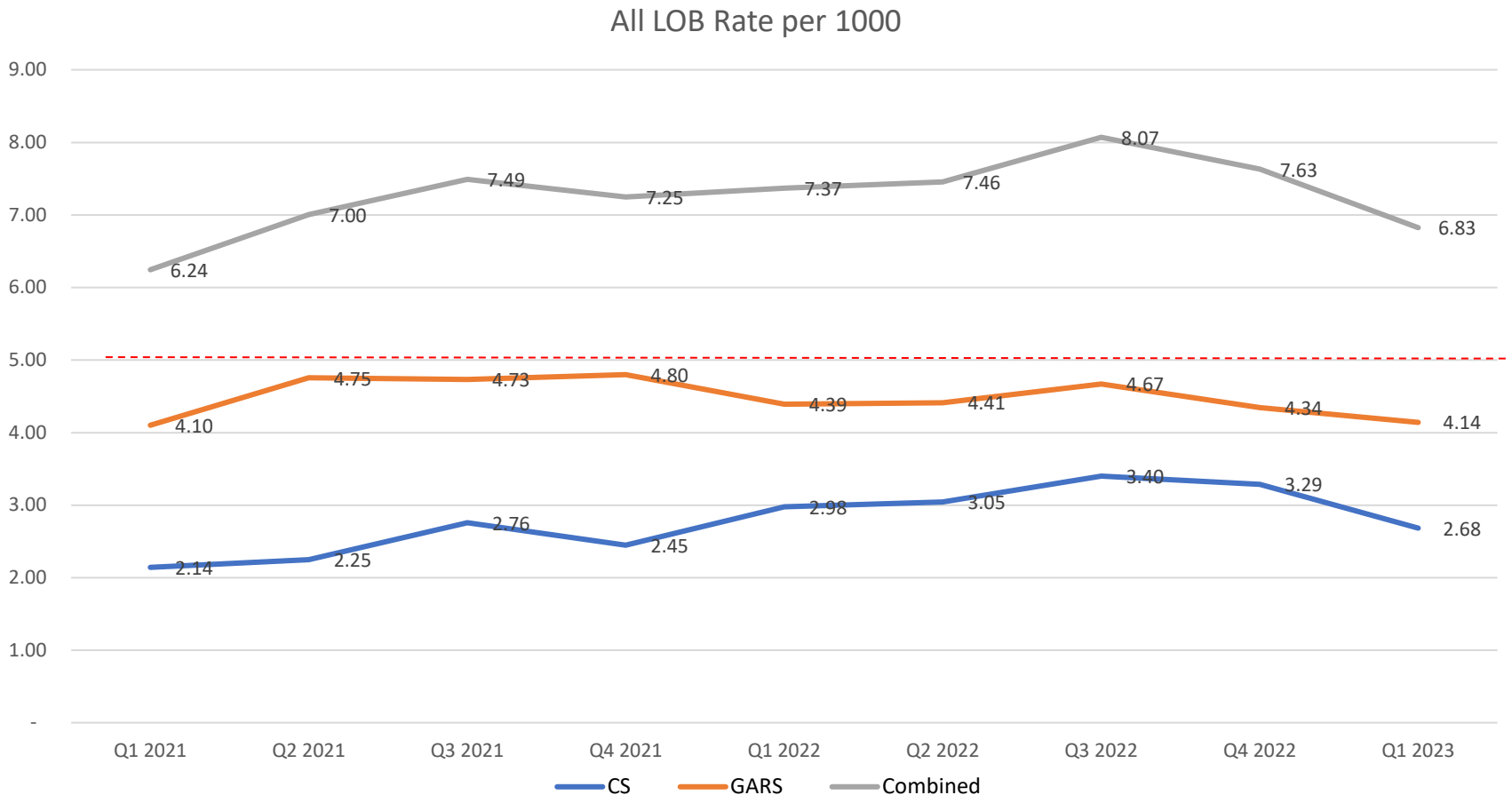
OneCare CalOptima Health

Combined Grievances



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Summary of Trends and Remediations

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Trending Factors for Each Category

Category	Issue	Case Resolution
Access to Care	• Appointment availability • Incorrect eligibility information	• Redirected members as appropriate • Assisted members with scheduling • Referral to QI when QOC is impacted
Member Billing	• Members being billed directly and not the Health Network	• Educated members on the importance of providing insurance information for claim submission • Educated providers on insurance/billing information and proper claims filing address

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Trending Factors Contd.

Category	Issue	Case Resolution
Quality of Care	• Delay in treatment • Questions in treatment • Lack of follow-up	• Referrals to QI • Individual Provider/Member engagement as appropriate • Reviewing for trends for PR or HNR education • Reporting to Member Experience any identified trends
Quality of Service	Transportation • Driver Issue • Early/Late Pickup	• Reporting to MTM • Review for possible QI components • Monitoring of repeat members for critical care or early morning monitoring team

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Remediation Activities

Identified Issues	Remediation Overview

• Delay in referrals:
  • Re-routes and resubmissions
  • Incomplete Sub-specialty list
	• Engaged UM – they are reviewing the current process for possible process changes
	• Considering education to the providers and/or modification of auth request form
	• Organization wide work group to identify sub-specialties

• Access - Appointment availability:
  • Increased demand
  • Staffing shortages
	• Reporting delays of extended wait times for scheduling appointments for intervention and reminder education on access and availability requirements – these are reported during case review
	• Reviewing and reporting trending specialties for possible contracting opportunities (Urology and Neurology were reported for Q1)

• Transportation - no shows or late arrivals	• GARS has created a dedicated team for all transportation grievances (lead by a former EMT) • Ongoing root cause analysis and collaboration with vendor to improve service

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Remediation Activities

Identified Issues	Remediation Overview

• Repeat grievances by same members:
  • Possible underlying BH issues
  • Members participating in CM were not involving their CM nurse in the issue they were grieving
	• Engaged BH for additional training of GARS staff to improve communication with members.
	• Gave access and trained CM on the appeals and grievances complaints to provide more visibility of member issues for clinical staff.

• Delay in receiving grievances:
  • Monarch forwarding grievances late
  • Convey forwarding grievances late
	• Scheduled call with Monarch – they agreed to the following:
	  • Improved monitoring to include 2 levels
	  • Hiring additional staff
	  • Received updated contacts from Monarch
	• Reported concerns to Pharmacy Department and Convey – Convey agreed to the following:
	  • Improved daily monitoring
	  • Cases are submitted on the day of the call
	  • Weekly summary report implemented

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